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ABSTRACT

This databook for the final report of the 10-year plan to redevelop services for individuals with intellectual disabilities in Victoria, Australia, presents results of three studies. The major study provides a functional profile of people with intellectual disabilities living in State-run institutions (Residential Training Centres) or attending Adult Day Training Centres (ADTCs). On a statewide basis, data are analyzed in terms of numbers and gender, age range, length of institutionalization or other living arrangement, family contact, secondary disabilities, and skill strengths in activities of daily life. Similar profiles are then offered for each of 10 individual training centers. The second study offers the views of 1,348 adults with intellectual disabilities living in institutions, toward proposals put forward in the interim report of the 10-year planning process. Respondents indicated that key issues in the redevelopment of intellectual disability services were access to community housing, employment, and further education. The third study presents, in summary form, a picture of the diversity of programs provided to clients by the ADTCs, such as vocational, pre-vocational, independent living skills, socialization, behavior management, paramedical services, recreation, and transport. A working paper relating to the prevalence of intellectual disabilities in Victoria is also included. An appendix contains a client profile checklist. (four references) (JDD)

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TEN YEAR PLAN FOR THE REDEVELOPMENT OF INTELLECTUAL DISABILITY SERVICES

FINAL REPORT
AUGUST 1988

EC 300018

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TEN YEAR PLAN FOR THE REDEVELOPMENT OF INTELLECTUAL DISABILITY SERVICES

FINAL REPORT
AUGUST 1988

Data Book

Neilson Associates Pty. Ltd.
Planning & Management Consultants

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TEN YEAR PLAN FOR THE REDEVELOPMENT OF INTELLECTUAL DISABILITY SERVICES

FINAL REPORT – DATA BOOK

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1. INTRODUCTION

As part of the Ten Year Planning Process, the project team conducted a number of large-scale data collection exercises to assist in the preparation of the Plan. Much of this information appears in ***Volume 2, The Quantification of the Task****, of the* ***Interim Report****, June 1987. However three studies were not completed at that stage and are presented here since widespread interest in our findings has been expressed.*

1.1 CONTENTS

The major study has provided a functional, as distinct from clinical, profile of people with intellectual disabilities who currently live in State-run institutions (Residential Training Centres) and also for those who attend Adult Day Training Centres (A.D.T.C.'s). This has yielded detailed data relating to some 5,500 clients of CSV/OIDS which was essential for our forward planning purposes.

As part of the Public Consultation Phase of our work, the project team also consulted with all adults now living in institutions as to their views about the proposals put forward in the Interim Report, June 1987. This study is also presented in this volume.

The third study presents, in summary form, a clearer picture of the actual diversity of programmes provided to clients by the A.D.T.C.'s. This was obtained by surveying all Centres in 1988.

Our working paper relating to the prevalence of intellectual disabilities in Victoria is also included in this volume due to the number of enquiries we have had for this information.

1.2 ACKNOWLEDGEMENTS

Many people assisted us in the various stages of this aspect of the project, and their interest, suggestions and assistance is greatly appreciated.

In terms of data collected in Training Centres, special thanks are extended to

- **the residents** who were so willing to discuss our proposals with us, including those more articulate people who assisted us when we had difficulty in communicating with some of their peers. To the people who we were unable to understand we apologize: hopefully we will refine our professional skills in this area so that, in the future, we can be of more assistance;
- **Unit staff, especially Charge Nurses,** who filled out individual profiles for each of their residents and, in many cases, provided sensitive assistance to us when we were consulting with clients;
- **the Management** of each Residential Training Centre and particularly **Nursing Administration**, who assisted us in gaining ready access to staff and clients;
- members of the **Parents and Friends Associations** who acted as independent observers during the Client Consultations in a number of Centres,and
- the **Hospital Employees Federation (No. 2) Sub-Branches** who ensured smooth access to staff at each Centre.

The people who assisted us in collecting Adult Day Training Centres data were Staff in Adult Centres, especially

- **Directors and Administrators** who filled out individual client profiles and survey questionnaires,and
- The **VTU and CIDA** who provided us with many helpful suggestions and assistance in this work.

To these people we extend our thanks, and in return hope that our findings as presented here are of use to them in delivering services to Victorians with intellectual disabilities.

Assistance in the actual entry and computer analysis of data presented here was provided by Margaret Kam, Robert Ciavarella and Tamara Betson.

Team members who worked on this aspect of the project were

Diane Berryman, Special Projects Officer—10 Year Plan
Doug Hoth, House Supervisor, Outer East
Denise Harrison, AHN, Kew Cottages
Con Tsingus, Adult Team, Western Suburbs
Peter Senini, Charge Nurse, Caloola Centre
Andrea Willerby, Charge Nurse, Kew Cottages
Heather Feldman, CSV, Western Suburbs
Cathy Boyd, Charge Nurse, St. Gabriels
Doug Marshall, CSV, Consultation Secretariat, Ballarat
Stuart Tilletson, Administrator, Melba Centre, ADTC
Bernadette Stumpf, Preston Northcote Helping Hand ADTC
Marion Welwood, Knoxbrook ADTC
Cathy Panayotides, Computer Operator
Tamara Betson, Computer Operator, Caloola Centre.

The prevalence working paper was prepared by Hadley Sides of Wilson, Sayer, Core Pty Ltd who was a member of the Consultants Team.

2. PROFILE OF RESIDENTIAL TRAINING CENTRE POPULATION

As noted in the ***Interim Report*** *of June 1987 (Volume 2, Page 22) a major difficulty encountered by the Study Team during the course of the project was the inadequacy of information relating to the characteristics of Victorians with intellectual disabilities.*

This section presents the functional profile of people living in Residential Training Centres that the Team developed as background information for use in preparing the Final Report of the Ten Year Plan.

2.1 STATEMENT OF PURPOSE

The primary purpose of this exercise was to develop a profile of clients residing in institutions which reflected their competencies in activities of daily life along with any secondary disabilities that they may have which would relate to service need and preliminary data as to the possible location of services to be developed so that we could base our recommendations to Government on an appraisal of actual consumer service need.

2.2 METHODOLOGY

2.2.1 Population and Settings

The population for this study was all people living in the eight CSV/OIDS Training Centres and two of the three Training Centre Sections of the joint Office of Psychiatric Services/Office of Intellectual Disability Services (OPS/OIDS) facilities during the period June to September, 1986.

These Centres are located across the State where Caloola, Kew Cottages, Janefield, Kingsbury and St. Gabriels Centres are located in metropolitan regions and Colanda, Pleasant Creek and Sandhurst Centres are in country regions. The two joint OPS/OIDS facilities, Aradale Hospital and Mayday Hills Hospital, are also located in rural regions. Brierly Hospital residents were not part of this study as a detailed study of the 26 men living in the Training Centre unit had been previously conducted using the same methodology and recommendations made for their relocation.

All people who comprised the study population were registered clients of CSV/OIDS and all were deemed to have an intellectual disability as defined under the **Intellectually Disabled Persons' Services Act, 1986**.

Raw data was collected at the residential unit or ward level in each Centre.

2.2.2 Measurement Instrument

An individual **Client Profile Instrument** (see appendix i) was developed by the project team specifically for this exercise since we were unable to locate a tool that met our requirements in terms of an emphasis on client competencies and relative ease of administration.

In order to make broad assumptions as to where services would be required, information was collected relating to were families lived and the amount and type of contact people had with their families as well as resident age and history of previous institutionalization.

Details of each person's secondary disabilities which have the potential to effect future service needs was collected by requiring the name of the disability as well as its effect on the mobility of the person.

Data pertaining to personal capabilities in the skills required in ordinary daily life, and hence possible primary service requirements, were also recorded. This community living skills component of our instrument, which yields scores at three levels of independence in ten skill domains (see Table 1) is an adaptation of the Mid-Nebraska Community Living Skills Screening Test—CLSST (Schalock & Gadwood, 1980). The empirical relationship between the discrete skill domains as shown in Table 2.1 and successful community living is detailed in the Standardization Manual of the CLSST (Schalock, 1980).

Basically, the CLSST (1980) is a criterion-referenced assessment tool designed primarily for use in setting and monitoring individualized developmental programming within a community-based Intellectual Disability Service. Through rigorous evaluation, and standardization procedures, the authors have been able to systematically ascertain which skills are functionally related to successful community living and to relate those skills to both training and placement activities (Shalock 1979; Schalock & Harper 1977; 1978; 1979; Schalock & Spearman, 1979).

In order to adapt this well researched and empirically validated **individual planning** and monitoring instrument to suit our State-wide **forward planning** purposes, we needed to made certain it could be quickly administered as a check list, but still retain validity. This was done by collapsing all discrete behaviours measured by the CLSST in each of the 10 domains to three behavioural statements, one at each level (see Table 2.1). Hence, our checklist had 30 behavioural statements representing the 174 discrete behaviour measured by the CLSST. Each behavioural statement has been weighted to reflect the number of discrete behavioural skills in each statement (see Table 2.1).

2.2.3 Data Collection and Analysis Procedures

Individual Client Profile Checklists for each resident of each institution were filled out by the regular Charge Nurse or Deputy Charge Nurse of each residential unit based upon their knowledge of the client. These staff members were all Registered Mental Retardation Nurses. If there was any uncertainty relating to checklist items, other unit staff were consulted.

A member of the study team, who was familiar with and experienced in using the original CLSST, visited each institution and trained a core of staff in the administration of the new instrument. Each Charge Nurse then filled out at least four checklists under the guidance of the trained person.

Data was analysed by the project team centrally using SAS Software package on the VAX mainframe computer system and the Omnis and Excel Software packages on the Apple MacIntosh System.

Table 2.1: COMMUNITY LIVING SKILLS PROFILE

Living Options	Fully Supported Living		Semi-Independent Living		Independent Living with or without Some Assistance	
	Discrete Skill Area	Weighting	Discrete Skill Area	Weighting	Discrete Skill Area	Weighting
Behaviour Domain						
1. Personal Maintenance	Grooming Skills	17	Health Care	6	Handles Medication	2
2. Dressing and Clothing Care	Dressing Skills	8	Laundry Skills	8	Clothing Repair/Replacement	5
3. Eating and Food Management	Independent Eating	5	Meal Preparation	12	Meal Planning and Shopping	4
4. Social Behaviour	Self Referenced Behaviours	5	Social Integration	8	Interpersonal Relations	4
5. Expressive Skills	Expresses Needs	3	Uses an Expressive Language System	5	Language Generalisation	2
6. Home Living	Cleaning Skills	12	Home Safety	6	Coping Skills	6
7. Money Management	Utility of Money	3	Money Concepts	7	Independent Money Usage	3
8. Time Awareness and Utilisation	Prompted Daily Routine	4	Unprompted Daily Routine	5	Independent Scheduling	3
9. Recreation and Leisure	Perceptual-Motor Skills	4	Recreation and Leisure Activities	5	Uses Community Recreation Facilities	2
10. Community Awareness and Utilisation	Community Awareness	3	Community Access	6	Independent Community Use	10
	Level 1		Level 2		Level 3	

Adapted by Ten Year Plan Project Team, 1988
from Mid-Nebraska Mental Retardation Services Inc. 1982

2.3. RESULTS

2.3.1 State-wide Profile of Residential Training Centre Population

- **Numbers and Gender**

On a state-wide basis, our data shows that during June to September, 1986 there were 2,672 people with intellectual disabilities living in State-run Residential Training Centres. Of these 45% (N = 1,200) were female and 55% (N = 1,472) male. 1,479 (55%) had also lived in at least one other residential institution prior to moving to their current locality.

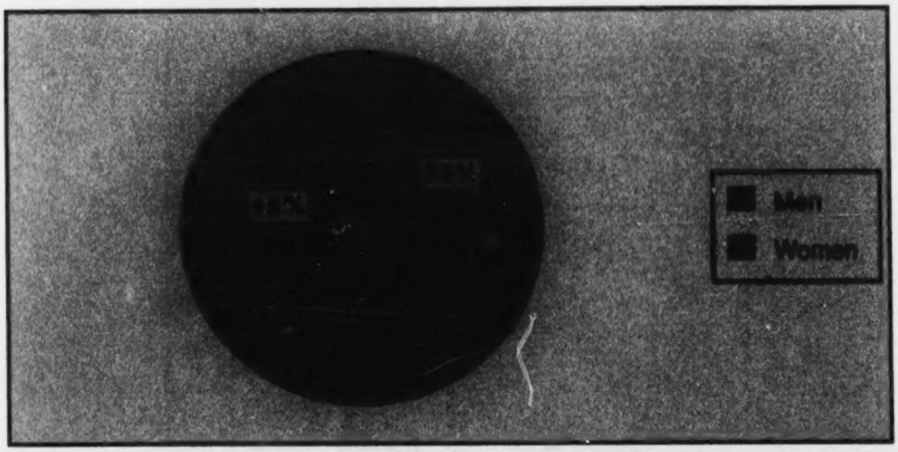

Figure 2.1: GENDER OF RESIDENTIAL TRAINING CENTRE RESIDENTS

- **Age Range**

Corrected to August 1988, our data shows that there were 88 (3%) children, 566 (21%) young adults, 1508 (56%) mature adults and 509 (19%) people over the age of 51 years living in the Training Centres.

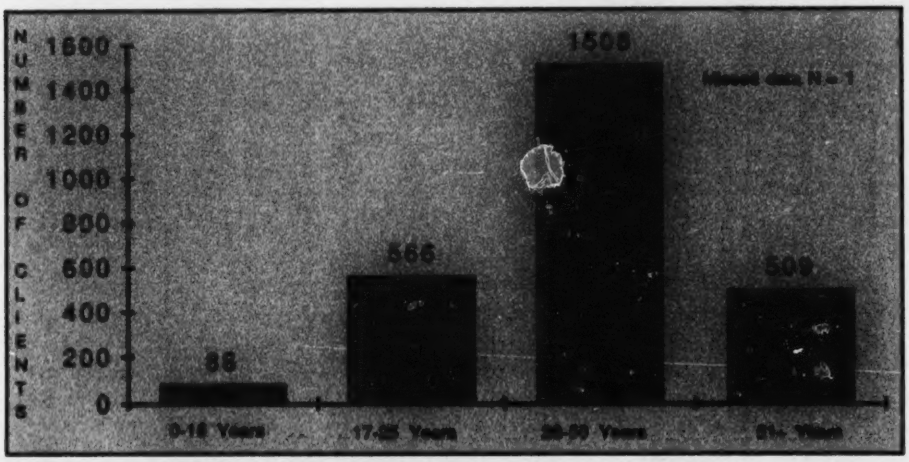

Figure 2.2: AGE OF RESIDENTS OF STATE RESIDENTIAL TRAINING CENTRES CORRECTED TO AUGUST 1988

▪ Length of Institutionalization

The greater majority, 43%, had lived in institutions between 11 and 20 years, 37% had been institutionalized for more than 21 years and 18% under 10 years. Data was not available for 2% of the population.

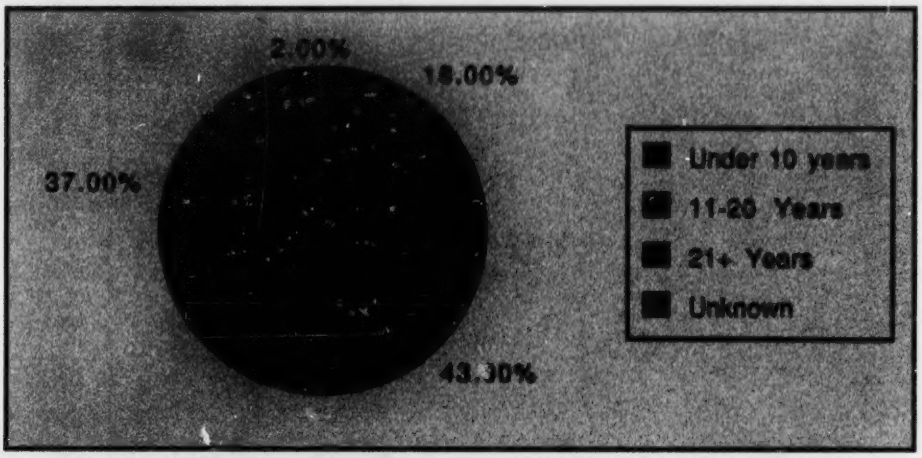

Figure 2.3: YEARS OF INSTITUTIONALIZATION OF RESIDENTIAL TRAINING CENTRE POPULATION

▪ Family Contact

Overall, 8% (N = 219) of residents had weekly contact with their families, 19% (N = 521) had monthly contact, 19% (N = 495) were in contact twice each year and 16% (N = 425) had contact approximately once per year. 861 people, or 32% of all Training Centre clients, had no contact with family members (see Figure 2.4). No information was available for 151 (6%) clients.

Contact with families took a number of forms: 656 (25% of all clients) people visited their families at home, 543 (20%) were visited in the institution by families and 441 (17%) received phone calls.

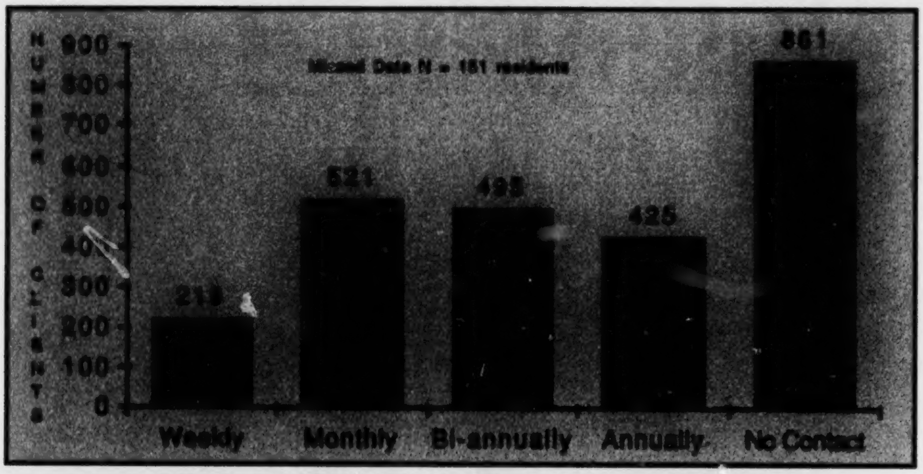

Figure 2.4: FREQUENCY OF TRAINING CENTRE RESIDENTS' CONTACT WITH FAMILIES

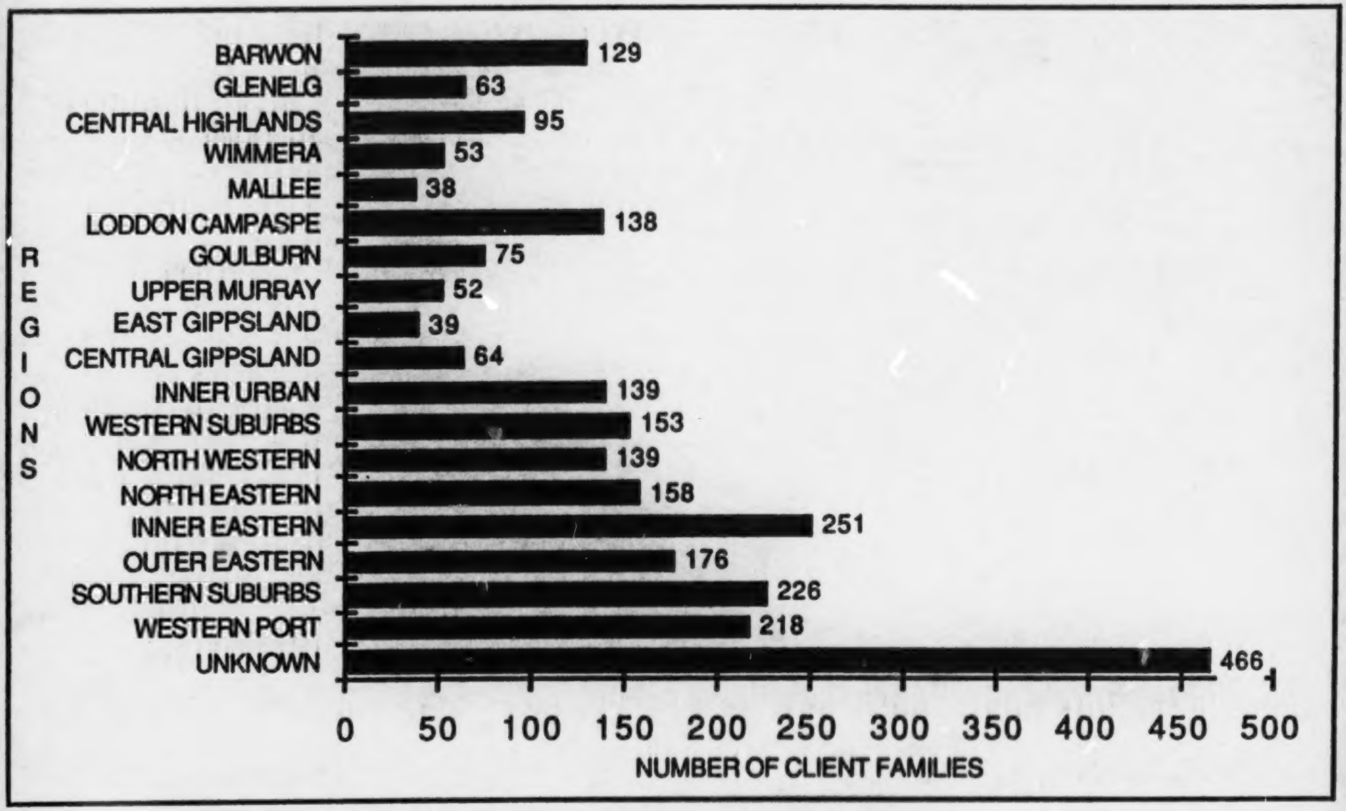

Figure 2.5: LOCATION OF RELATIVES OF TRAINING CENTRE CLIENTS

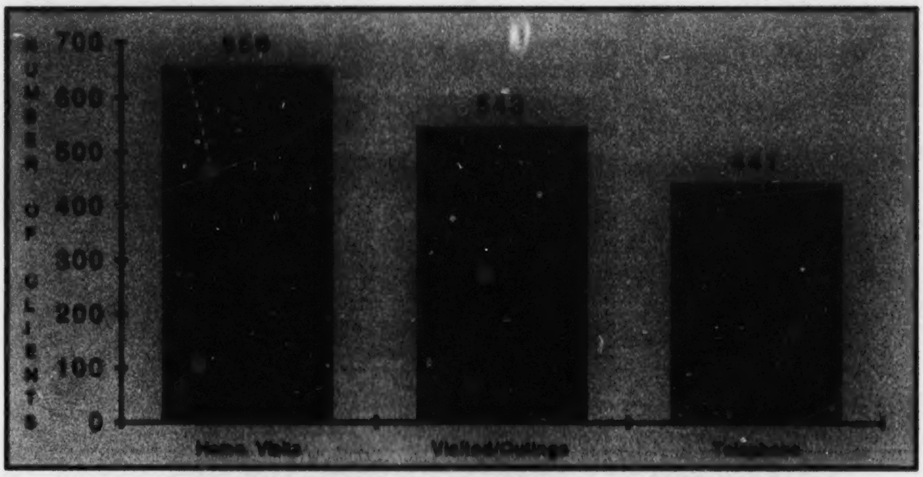

Figure 2.6: TYPE OF CONTACT FAMILIES HAD WITH TRAINING CENTRE RESIDENTS

- **Location of Families**

The Region in which relatives of institution clients lived is summarized in Figure 2.5. As can be seen, our data indicates that families were located across the State, and the number varied from 251 (9%) families in the Inner Eastern Suburbs to 35 (1%) in the Mallee. 466 or 17% of all Training Centre clients did not have any known relatives in Victoria. Many of this latter group had no contact with anyone outside of the Training Centre.

- **Secondary Disabilities**

Figure 2.7 summarizes the reported extent of secondary disabilities experienced by residents in addition to their intellectual disability. As can be seen, 17% of people had a visual disability, 11% had a diagnosed hearing loss, 7% had a motor disability resulting from cerebral palsy and 15% had some other form of motor disability.

It was reported that 17% exhibited severe self-stimulatory or self-abusive behaviours on a regular basis and that 22% demonstrated social behaviours *in the institutional setting*, which required a behaviour management programme. This data should, however be treated with caution, as it is well documented that much of human behaviour is situation specific—that is, behaviour exhibited in one setting will not necessarily be generalized to other settings. This is especially so for people with intellectual disabilities.

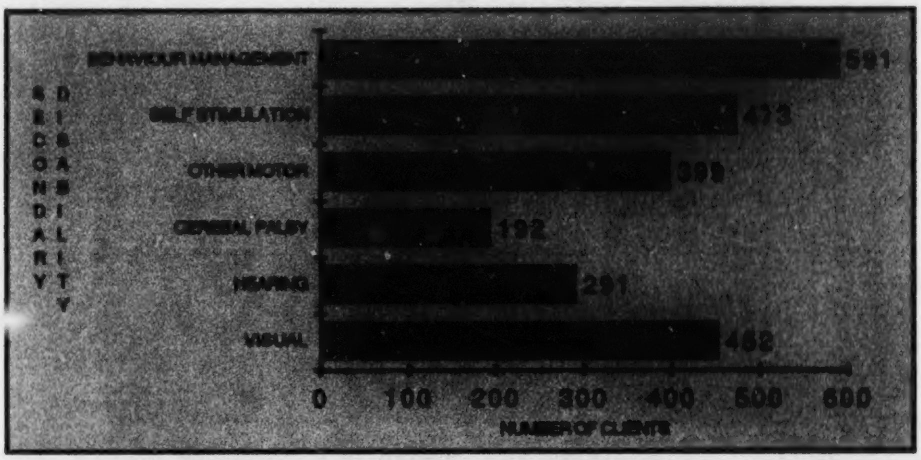

Figure 2.7: SECONDARY DISABILITIES EXPERIENCED BY RESIDENTS OF STATE RESIDENTIAL TRAINING CENTRES

▪ Multiple Disabilities

When the above data was further analysed in order to examine the prevalence of multiple disabilities experienced by Training Centre residents, it was revealed that of the 452 people who had a visual disability, 8% also had Cerebral Palsy, 17% had other motor disabilities and 30% had a diagnosis hearing disability. Of the 291 residents who had a hearing loss, 5% also had cerebral palsy and 15% had other motor disorders.

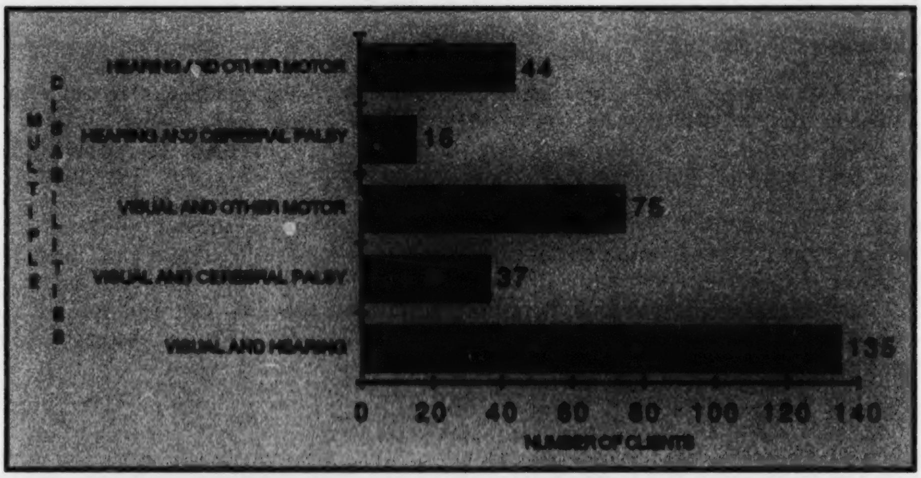

Figure 2.8: NUMBER OF TRAINING CENTRE CLIENTS EXPERIENCING MULTIPLE DISABILITIES

▪ Medical Conditions

The extent of diagnosed medical conditions of this population is shown in Figure 2.9. Our data indicates that 224 people had a diagnosed psychiatric disorder, (i.e. 8% of institution population), epilepsy was the most prevalent medical disorder, where 27% residents had grand-mal seizures, 5% had petit-mal seizures and it was reported that 3% of these people could go into status epilepticus. 17% people had some other form of medical condition, 32% were incontinent at night and 27% during the day.

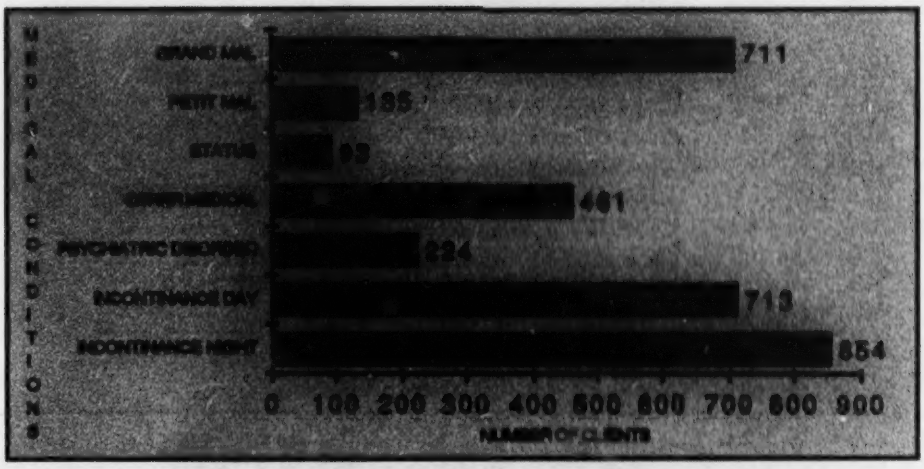

Figure 2.9: MEDICAL CONDITIONS OF RESIDENTS OF STATE RESIDENTIAL TRAINING CENTRES

▪ Skill Strengths in Activities of Ordinary Daily Life

Our analysis of the levels of critical community living skills **actually performed by residents on a regular basis**, as measured by our adaptation of the Mid-Nebraska Community Living Skills Screening Test is presented in figures 2.10, 2.11 and 2.12.

These figures present the total number of residents who were independent in each of the ten behavioural domains at the three levels of independence detailed in Table 2.1.

In terms of basic skills, (Figure 2.10) our data indicates that the largest number of residents independently expressed their needs (59% of all people living in Training Centres), independently used basic perceptual motor skills (56%) and ate their food without assistance (52%). It was reported that few people regularly attended to their personal grooming without assistance (24%) or independently engaged in basic cleaning activities (13%).

As can be seen in Figure 2.11, our data shows that the skills required for semi-independent community living were actually performed by very few people in the institutional setting. However, 47% did use the expressive language skills required for this form of community life.

Figure 2.12 indicates very few residents regularly displayed the behaviour patterns of people who live independently in the community.

When interpreting this data in this section, it is important to realize that this data does not address the **capabilities** of Training Centre residents. **The reasons** why people do not regularly perform skills include:

a) They may not get the opportunity to engage in an activity because someone else does it for them.
b) There is no need to learn and/or perform the skill within the institutional environment.
c) They are unable to perform the skill.
d) They do not want to perform the skill.

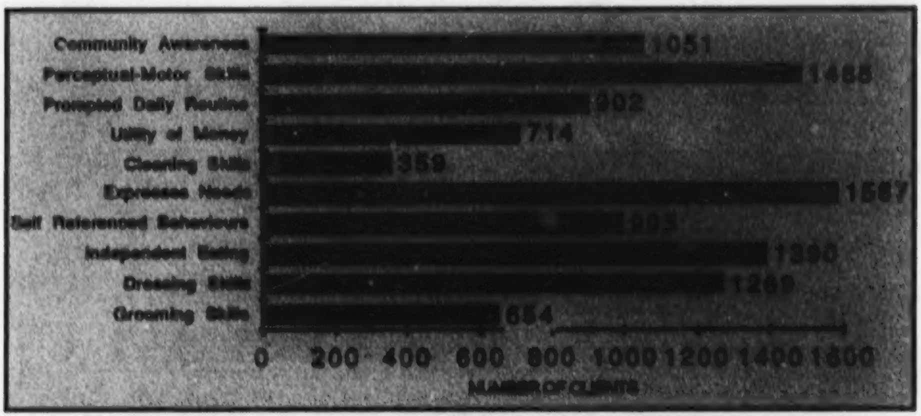

Figure 2.10: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF TRAINING CENTRE RESIDENTS

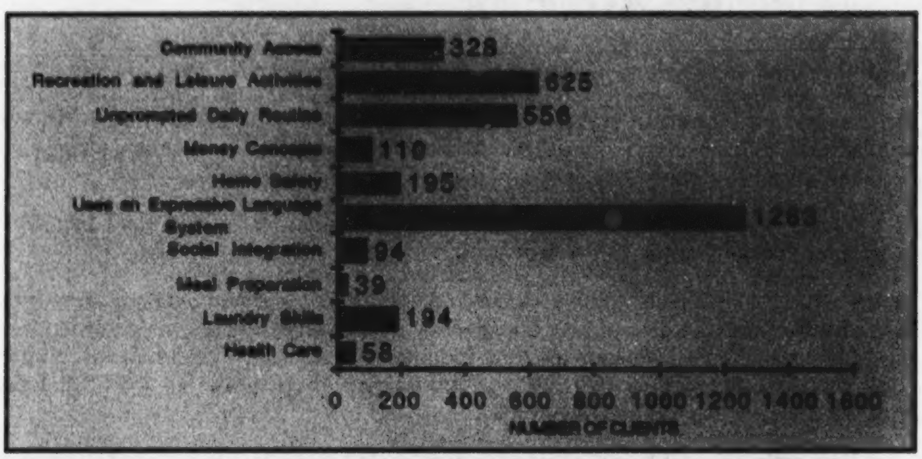

Figure 2.11: LEVEL 2: INDEPENDENCE IN SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF TRAINING CENTRE RESIDENTS

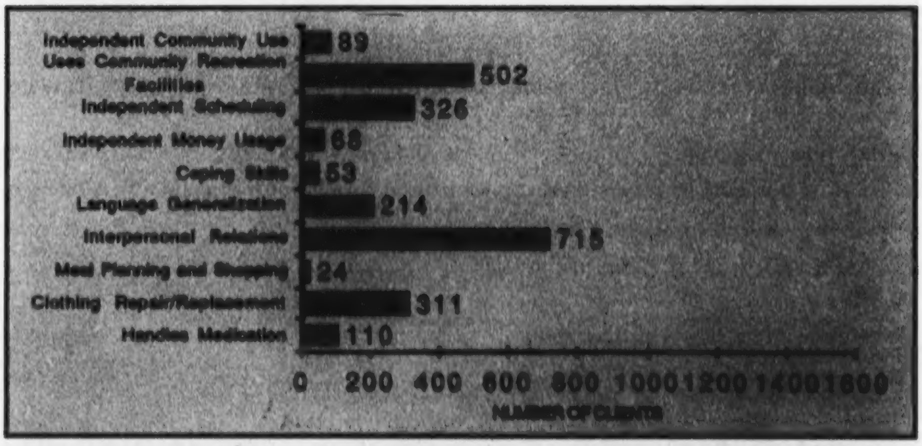

Figure 2.12: LEVEL 3: INDEPENDENCE IN SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF TRAINING CENTRE RESIDENTS

2.3.2 Profile of Resident Population of Aradale Training Centre Wards

- **Number and Gender**

At the time of our data collection (June-September 1986) there were 230 people with intellectual disabilities living in the Training Centre wards at Aradale Psychiatric Hospital in Ararat, of whom 167 were men and 63 were women. 203 (63%), had also lived in at least one other residential institution before moving to Aradale.

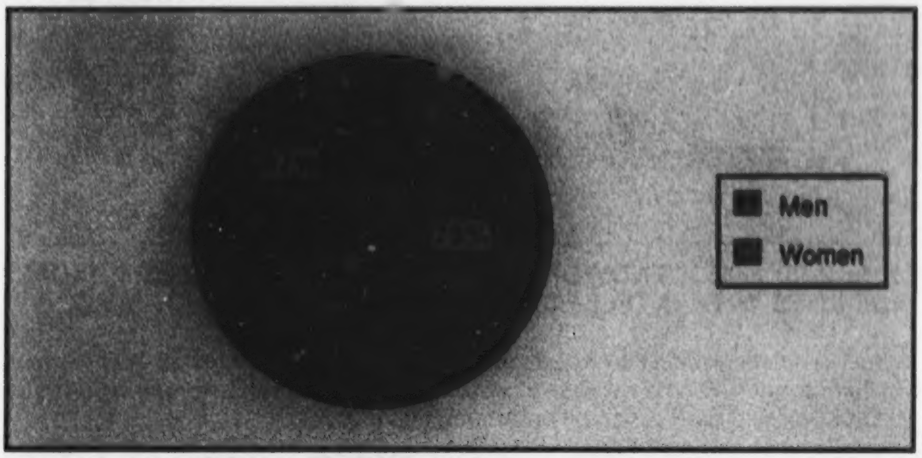

Figure 2.13: GENDER OF PEOPLE WITH INTELLECTUAL DISABILITIES RESIDING IN ARADALE HOSPITAL

- **Age Range**

As shown in Figure 2.14, 1% were aged between 17 and 25 years, 52% were aged 26 to 50 years and 45% were over the age of 51 years. These figures are corrected to August, 1988.

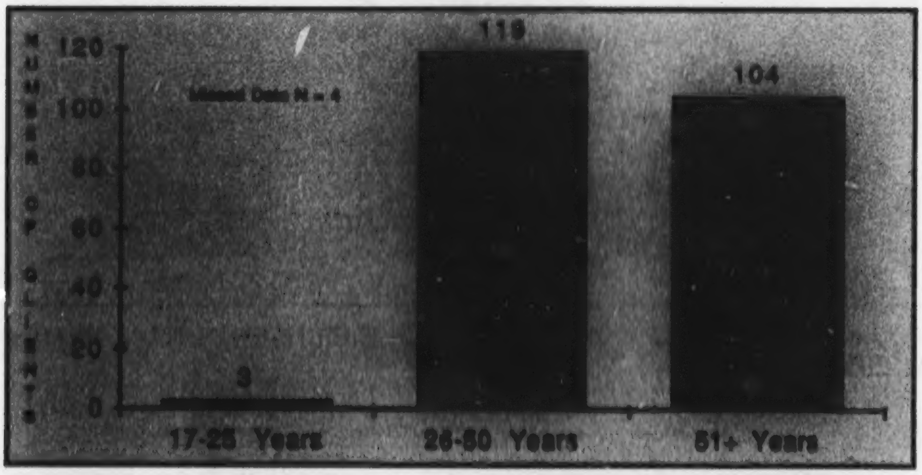

Figure 2.14: AGE RANGE OF ARADALE RESIDENTS CORRECTED TO AUGUST 1988

▪ Family Contact

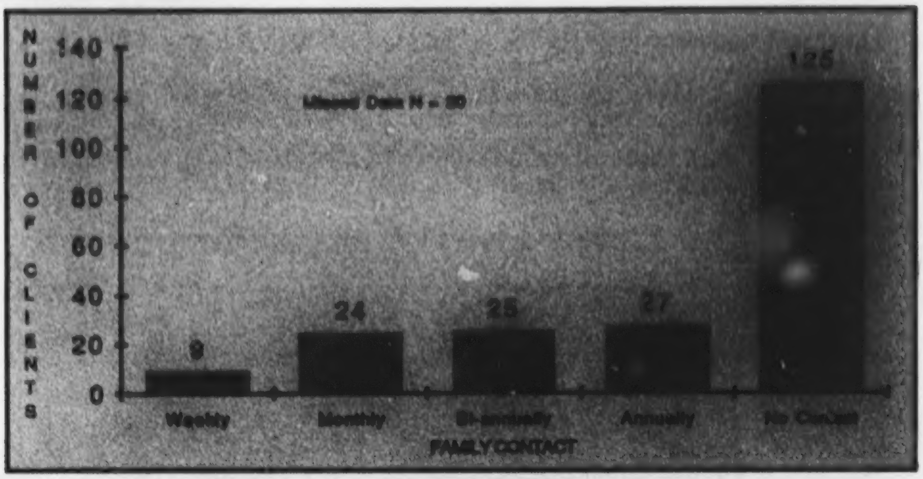

Figure 2.15: FREQUENCY OF CONTACT WITH FAMILIES BY ARADALE RESIDENTS WITH INTELLECTUAL DISABILITIES

Of the 230 people with intellectual disabilities living at Aradale Hospital, 4% have weekly contact with their families, 10% have monthly contact, 10% have contact twice per year, 11% have contact once per year and 54% have no contact (see figure 2.15).

The type of contact residents had with their families is displayed in Figure 2.17. This indicates that the most common form was visits from families which may or may not have included an outing.

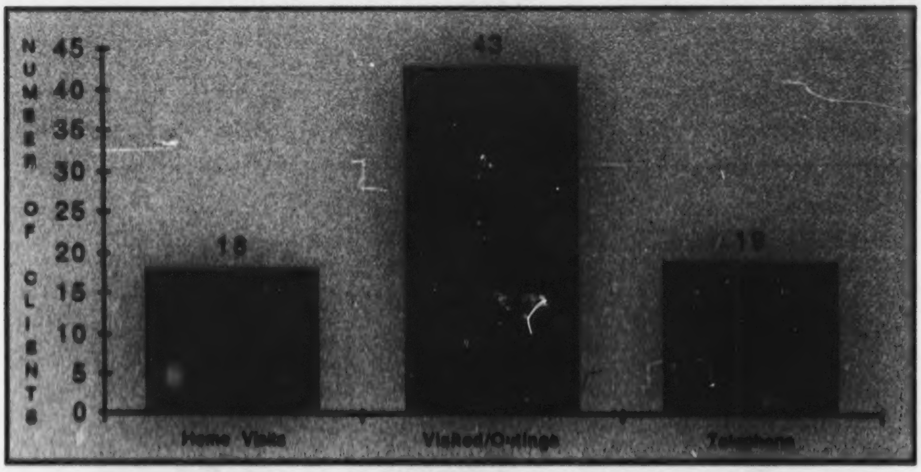

Figure 2.16: TYPE OF CONTACT ARADALE RESIDENTS HAVE WITH THEIR FAMILIES

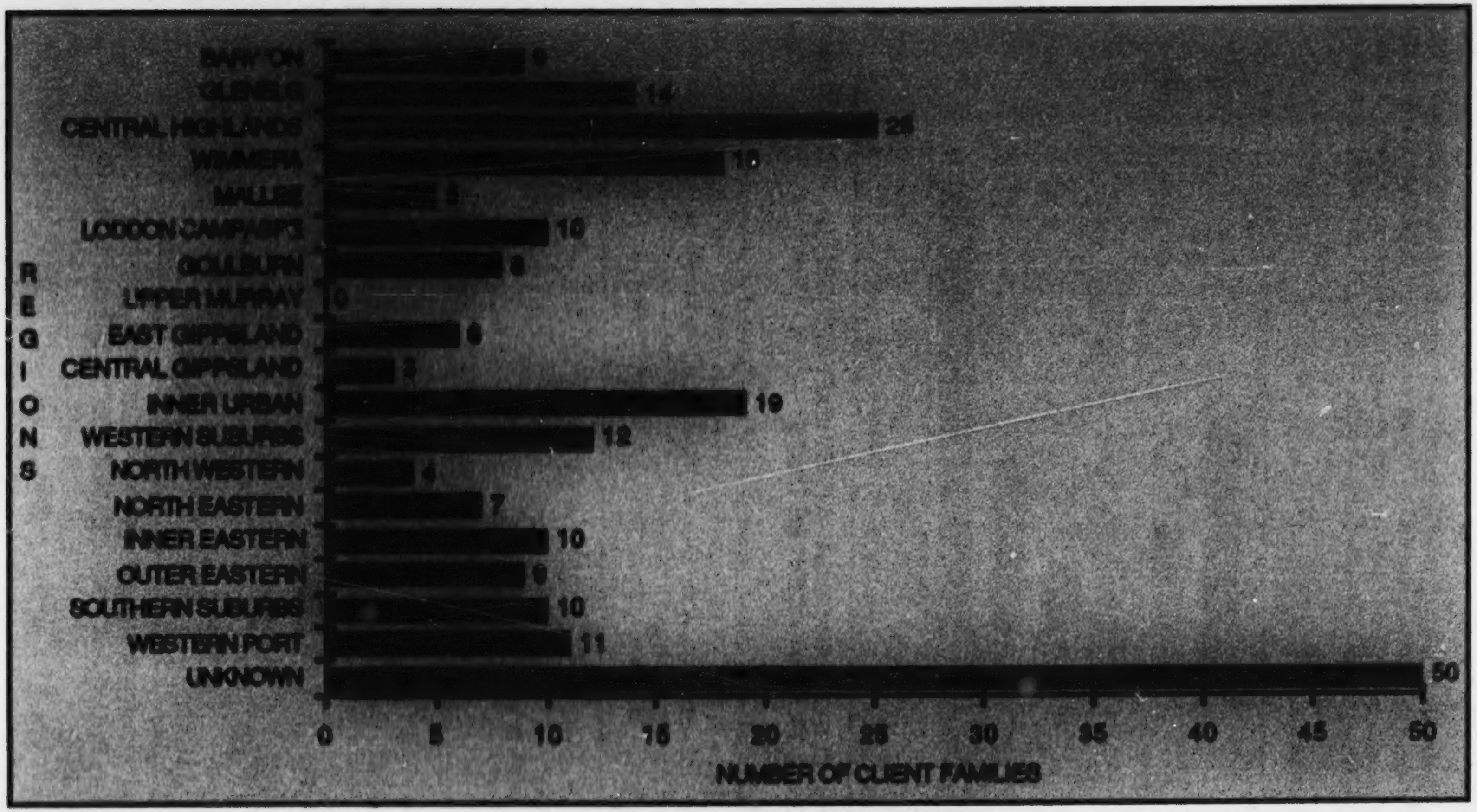

Figure 2.17: REGIONS IN WHICH RELATIVES OF ARADALE RESIDENTS LIVE

▪ Location of Families

As shown in Figure 2.17, families of Aradale residents were distributed across all regions of Victoria with the exception of the Mallee. The greatest proportion (11%) lived in the Central Highlands where Aradale itself is located with 9% in the Wimmera, a neighbouring region. However, 9% also came from the Inner Urban Region. The whereabouts of families of 22% of residents was not known.

▪ Secondary Disabilities

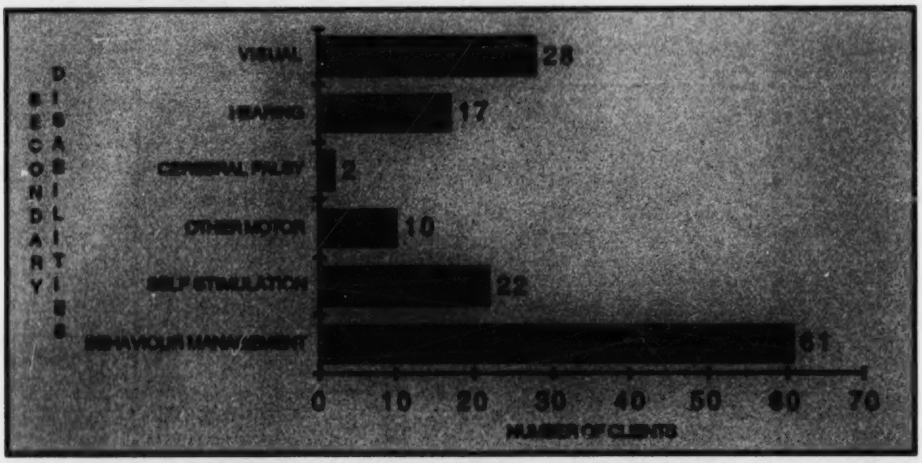

Figure 2.18: SECONDARY DISABILITIES EXPERIENCED BY RESIDENTS OF ARADALE TRAINING CENTRE UNITS

The reported secondary disabilities experienced by Aradale residents in addition to their intellectual disability is shown in Figure 2.18. As can be seen a visual disability was the most prevalent sensory disability (12% of clients). 26% of the 230 residents also exhibited social behaviours in the institutional setting which required a behaviour management programme. There was however, little relationship between secondary disabilities and social behavioural difficulties (Figure 2.19) according to our data.

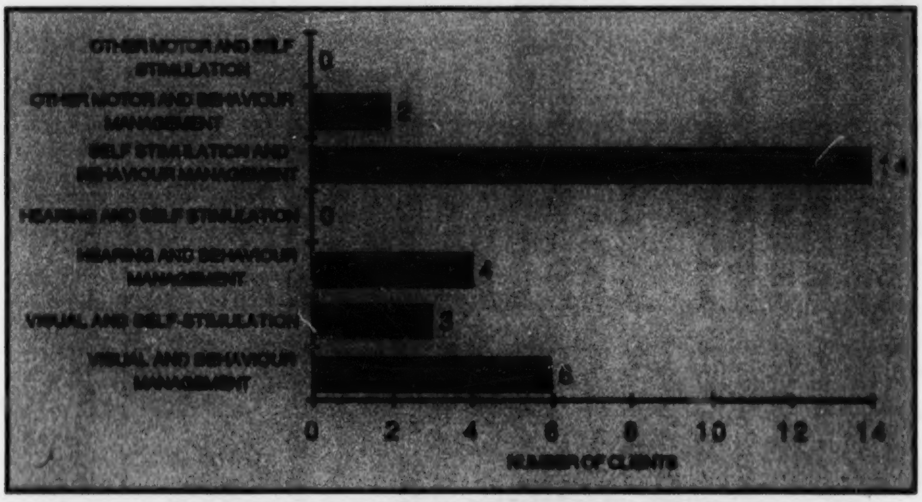

Figure 2.19: NUMBER OF ARADALE RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO THEIR SECONDARY DISABILITIES

▪ Multiple Disabilities

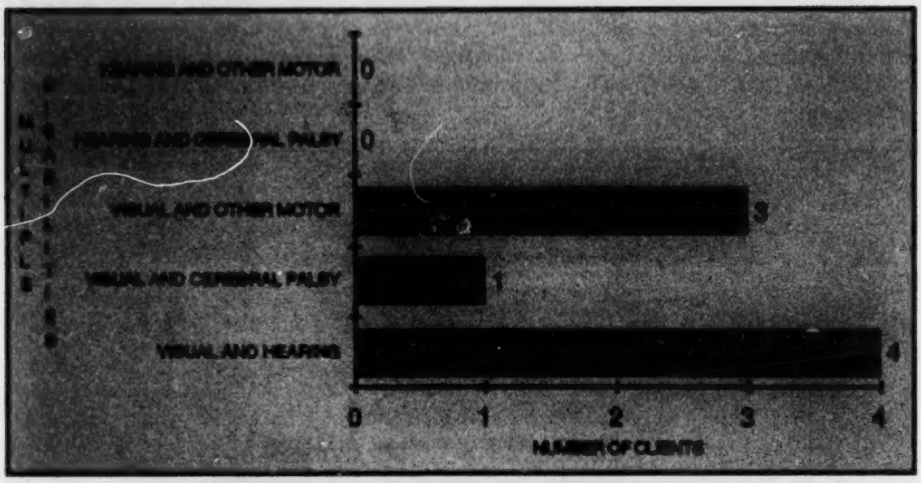

Figure 2.20: NUMBER OF ARADALE RESIDENTS EXPERIENCING MULTIPLE DISABILITIES

Our data indicates that few people living at Aradale had multiple disabilities. (Figure 2.20)

▪ Medical Conditions

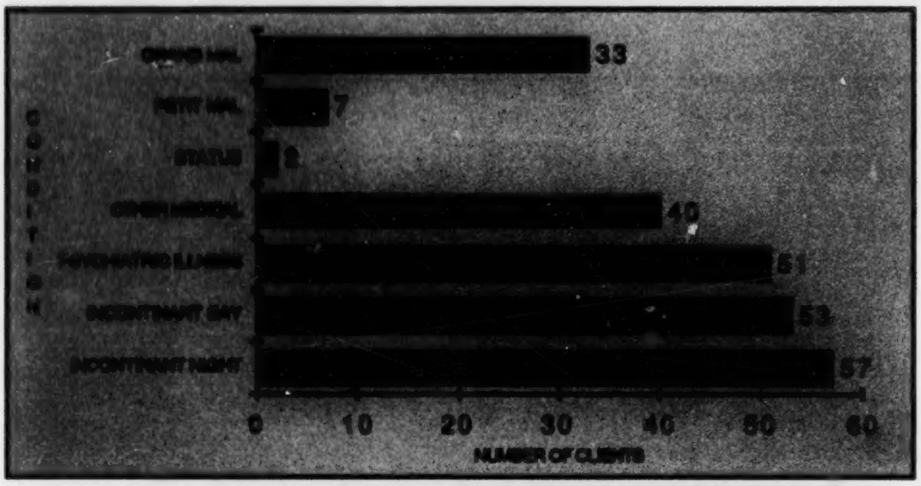

Figure 2.21: MEDICAL CONDITIONS OF ARADALE RESIDENTS

As shown in Figure 2.21, 22% of Aradale residents had a diagnosed psychiatric illness, which is much higher than the 8% of all Training Centre clients reported in an earlier section, and incontinence was the major medical condition amongst this group of people.

▪ Skill Strengths in Activities of Ordinary Daily Life

Figures 2.22, 2.23 and 2.24 display the reported skill strengths in activities of daily life actually performed by Aradale clients. As mentioned in the State profile (2.3.1) these represent what residents actually do in their daily lives and not what they can do, or what they are capable of learning.

The summary of basic skills performed by Aradale residents is presented in figure 2.22. When compared with state wide figures (see previous section) they indicate that a higher percentage of people at Aradale perform all basic skills on a regular basis. This is especially so in relation to performing prompted daily routine (62% of Aradale people compared with 35% statewide), dressing skills (73% compared with 47%) grooming skills (40% compared with 24%) and independent eating (68% compared with 52%.

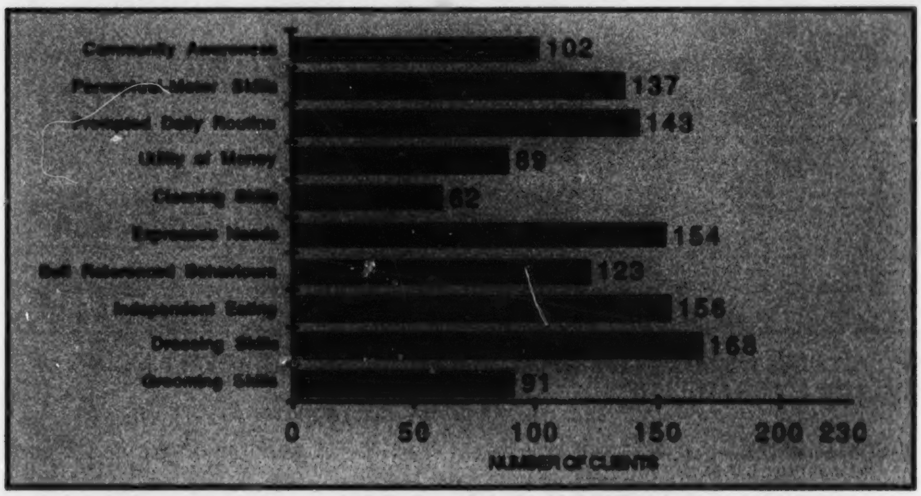

Figure 2.22: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF ARADALE RESIDENTS

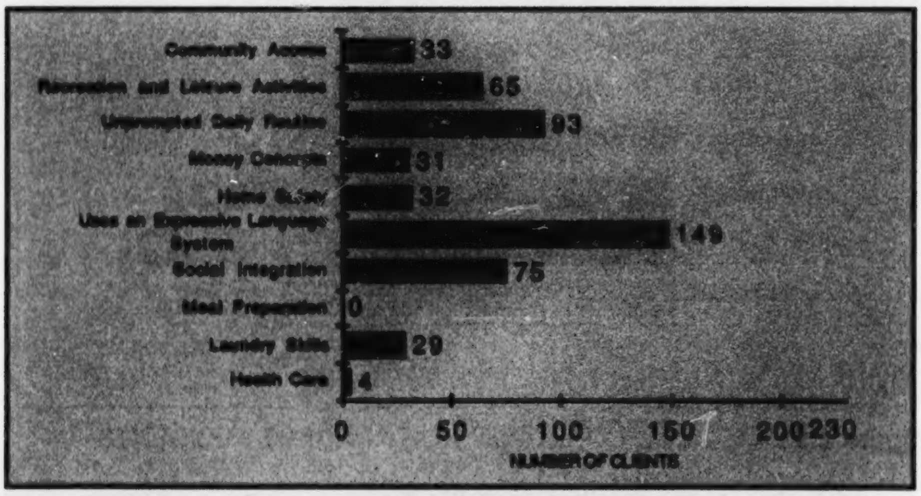

Figure 2.23: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF ARADALE RESIDENTS

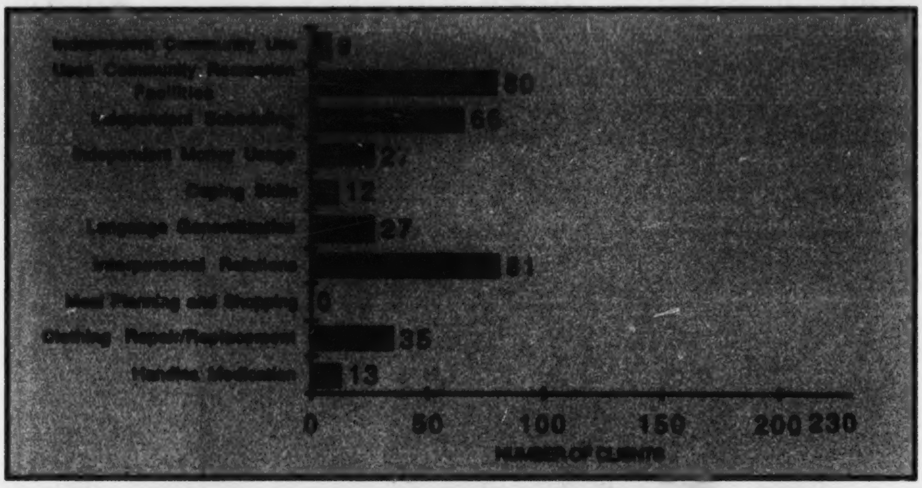

Figure 2.24: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF ARADALE RESIDENTS

This trend continues in relation to those skills required for semi-independent living. When compared with the statewide Training Centre population a greater proportion of Aradale clients performed all of the skill areas, with the exception of meal preparation, in the course of their daily lives. This is most marked for use of expressive language (65% of residents compared with 47%) and independence in the daily routine (40% compared with 21%).

Figure 2.24 indicates at a greater proportion of Aradale clients also exhibit those skills required for independent living when compared with statewide data. This is especially noticeable in terms of use of community recreation facilities (35% of clients compared with 19% statewide) and independent scheduling (39% compared with 12%).

2.3.3 Profile of Resident Population of Mayday Hills Training Centre Wards

- **Number and Gender**

During June-September 1986, there were 176 people with intellectual disabilities living in the Training Centre wards at Mayday Hills Psychiatric Hospital in Beechworth, of whom 50 were men and 126 were women. 153 (87%) had also lived in at least one other residential institution before taking up residence at Mayday Hills. (see Figure 2.25).

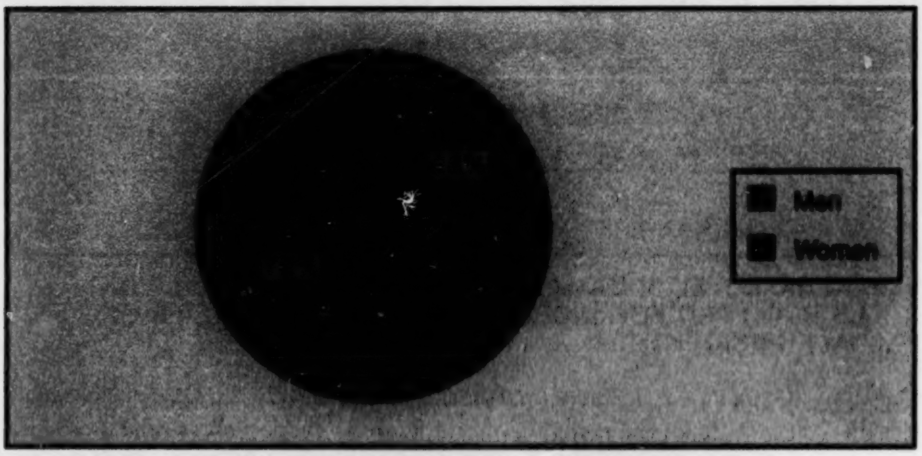

Figure 2.25: GENDER OF PEOPLE WITH INTELLECTUAL DISABILITIES LIVING AT MAYDAY HILLS HOSPITAL

- **Age Range**

According to our data which has been corrected to August 1988, 46% people were between the age of 26 and 50 years, 52% were over the age of 51 years and only four people were under 25 years of age.

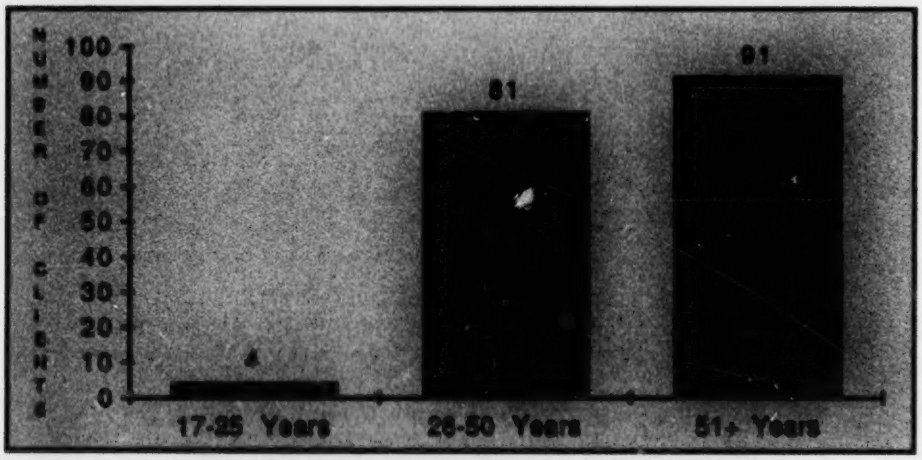

Figure 2.26: AGE RANGE OF MAYDAY HILLS RESIDENTS CORRECTED TO AUGUST 1988

▪ Family Contact

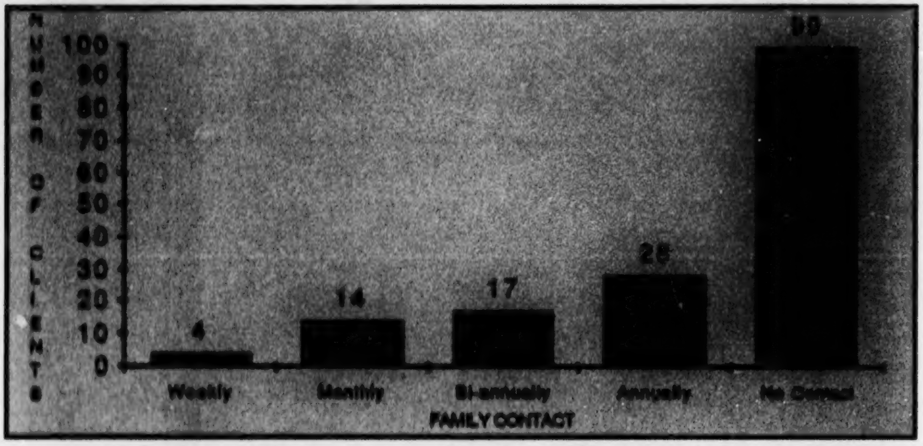

Figure 2.27: FREQUENCY OF CONTACT WITH FAMILIES BY MAYDAY HILLS RESIDENTS

As shown in Figure 2.27, 2% of residents had weekly contact with families, 8% had monthly contact, 10% were contacted twice per year and 16% had annual contact. It was reported that 56% had no contact with their families.

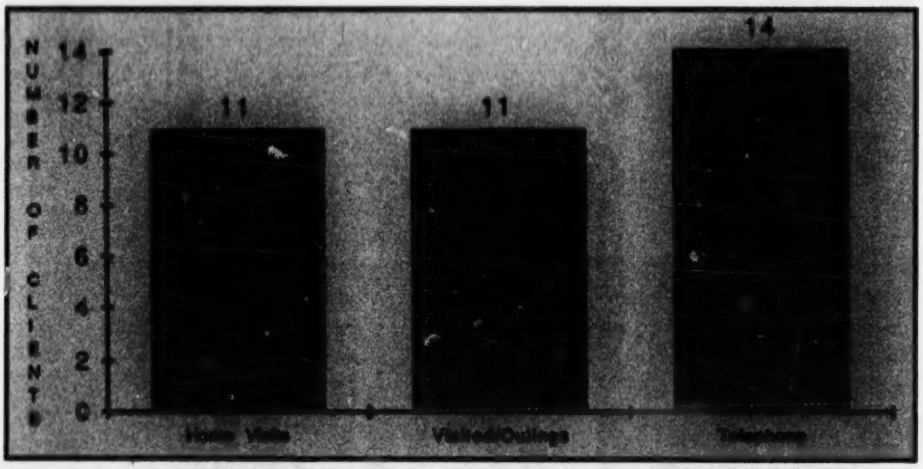

Figure 2.28: TYPE OF CONTACT MAYDAY HILLS RESIDENTS HAD WITH THEIR FAMILIES

As shown in Figure 2.28, the most usual form of contact people living in Mayday Hills had with families was by telephone.

▪ Location of Families

The largest proportion of known families of Mayday Hills residents lived in the Upper Murray Region (16%), the region in which Mayday Hills is located and in the neighbouring region of Goulbourn (7%), however, families were scattered across Victoria. It was reported that 33% of Mayday Hills people had no known families.

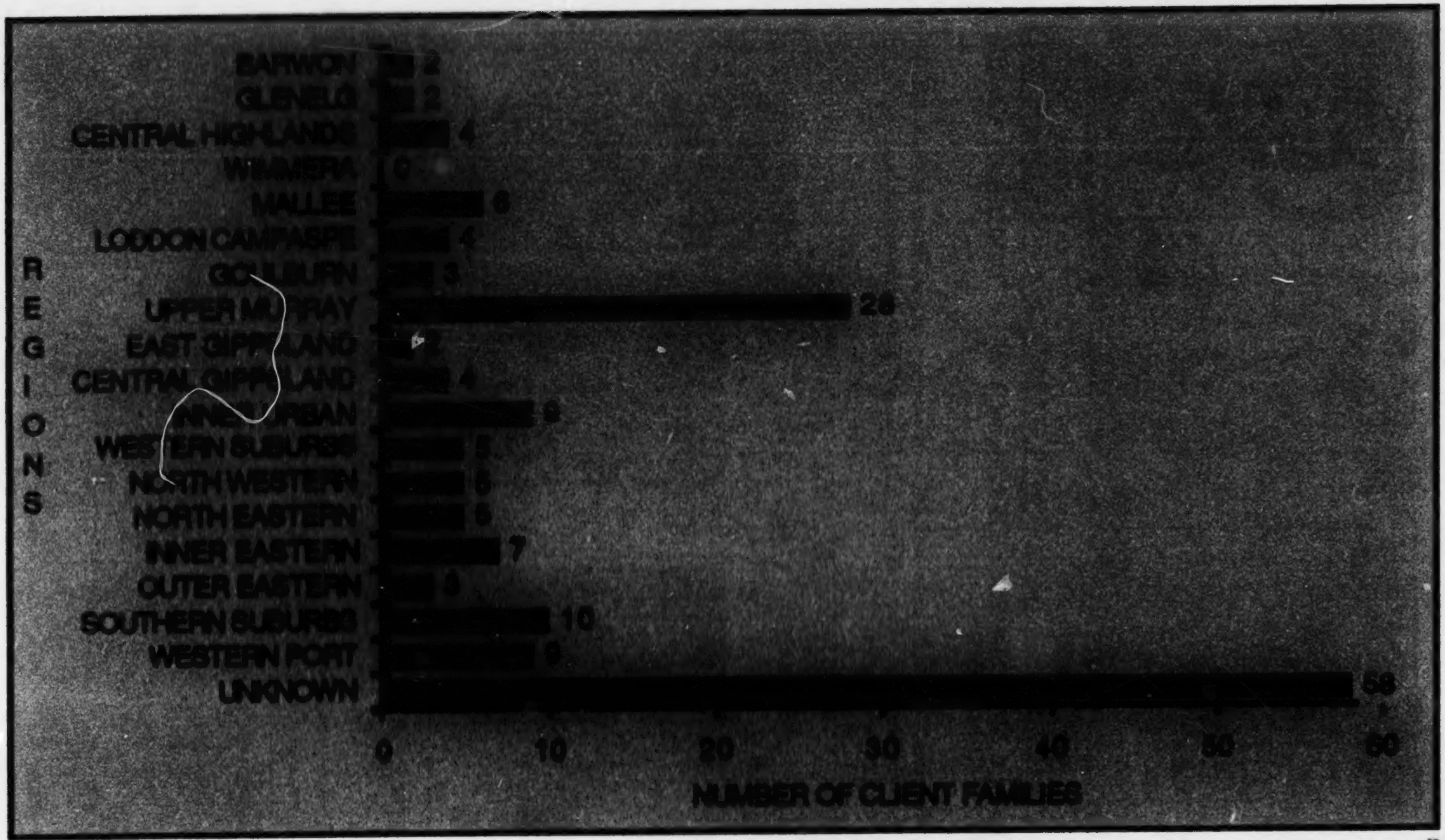

Figure 2.29: REGIONS IN WHICH RELATIVES OF MAYDAY HILLS RESIDENTS LIVE

- **Secondary Disabilities**

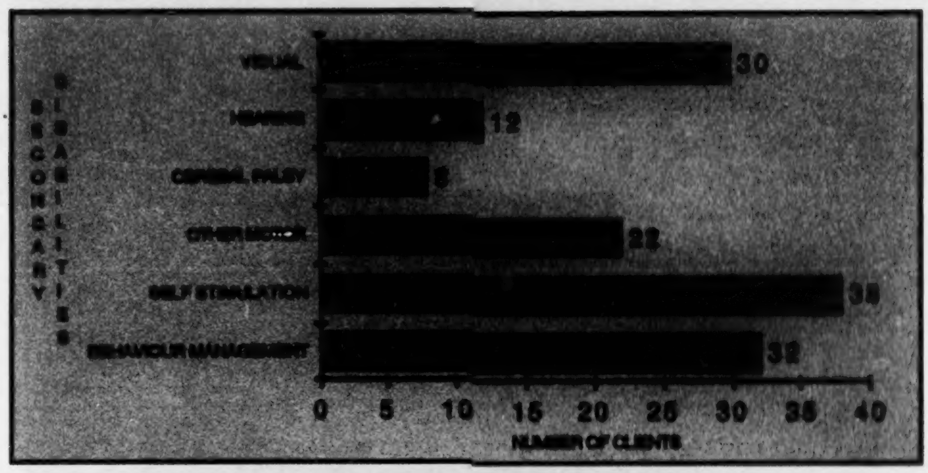

Figure 2.30: SECONDARY DISABILITIES EXPERIENCED BY RESIDENTS OF MAYDAY HILLS TRAINING CENTRE UNITS

The summary of secondary disabilities experienced by the residents of Mayday Hills Training Centre wards indicates that the most prevalent sensory disability was a visual one (17% of all residents) and that 13% experienced motor disabilities other than cerebral palsy (5%). 7% had a significant hearing loss, 22% exhibited repetitive self-stimulatory or self abusive behaviours and 18% require a behaviour management programme for the social behaviours exhibited in the institutional setting. Data presented in Figure 2.30 indicates that the incidence of social behavioural difficulties in addition to secondary sensory and motor disabilities was not great.

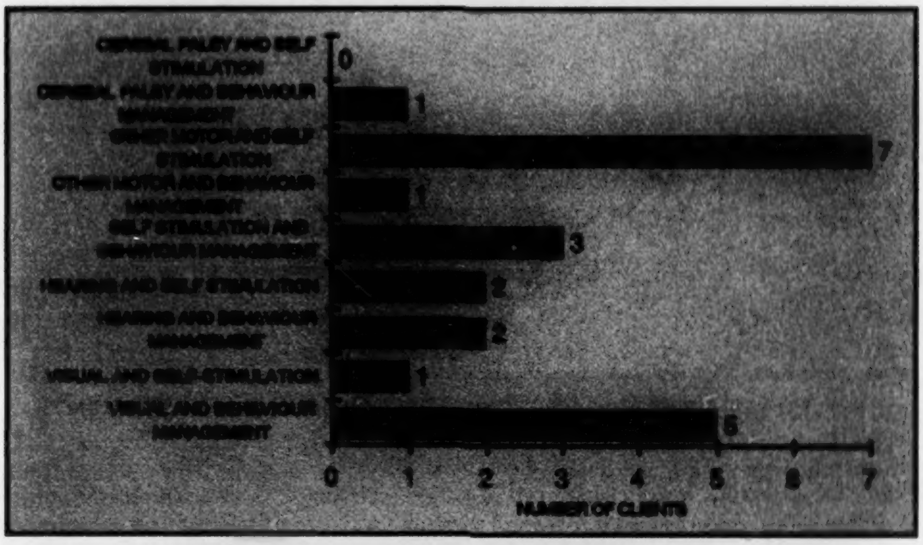

Figure 2.31: NUMBER OF MAYDAY HILLS RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO SECONDARY DISABILITIES

■ Multiple Disabilities

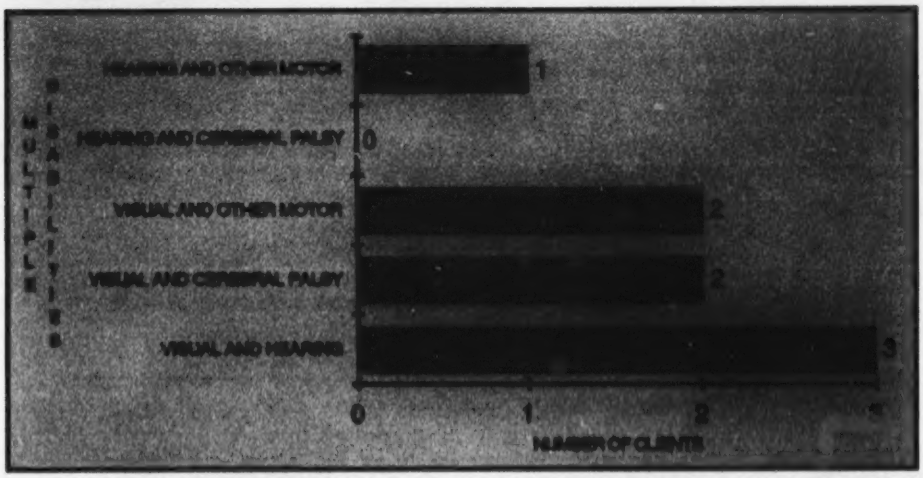

Figure 2.32: NUMBER OF MAYDAY HILLS RESIDENTS EXPERIENCING MULTIPLE DISABILITIES

As indicated in Figure 2.32, it was reported that few people at Mayday Hills experienced multiple disabilities.

■ Medical Conditions

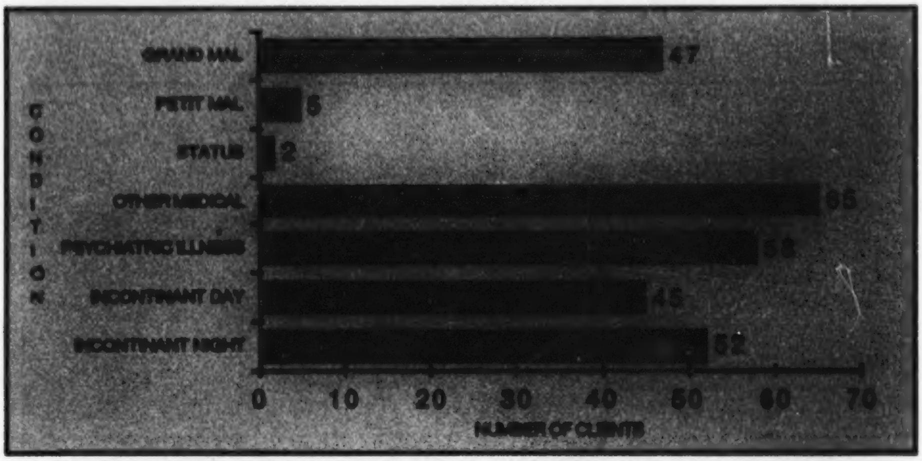

Figure 2.33: MEDICAL CONDITIONS OF MAYDAY HILLS RESIDENTS

As shown in Figure 2.33, our data indicates that 33% of the people living in the Training Centre Units at Mayday Hills hospital had a diagnosed Psychiatric disorder, which is much higher than the overall 8% of people with intellectual disabilities living in Training Centres across the state as is the incidence of other medical conditions (37% compared with 17% statewide).

■ Skill Strengths in Activities of Ordinary Daily Community Life

The reported basic skills actually performed by Mayday Hills is summarized in Figure 2.34. This indicates that, compared with the Statewide Training Centre data presented in figure 2.10 more Mayday Hills residents independently engaged in a prompted daily routine (45% compared with 34%) and eating without assistance (66% compared with 52%) and that less Mayday Hills people demonstrated community awareness (27% compared with 39% statewide) and basic preceptual motor skills (33% compared with 56% statewide).

Figure 2.35 summaries the number of Mayday Hills people who actually performed those skills required for semi-independent community life without assistance on a regular basis. When this data is compared with the Statewide Training Centre client profile (figure 2.11), our data indicates that more Mayday Hills clients engaged in community access activities (27% compared with 12%) but demonstrated less independence in recreation and leisure activities (11% compared with 23%).

The numbers of Mayday Hills residents who independently engaged in those activities required for independent life are shown in Figure 2.36. When this is compared with the Statewide Training Centre profile, it is revealed that the proportions are similar, except that a considerably higher proportion of Mayday Hills people demonstrated independence in inter personal relations (39% compared 27%) and handling of medication without assistance (21% compared with 4%).

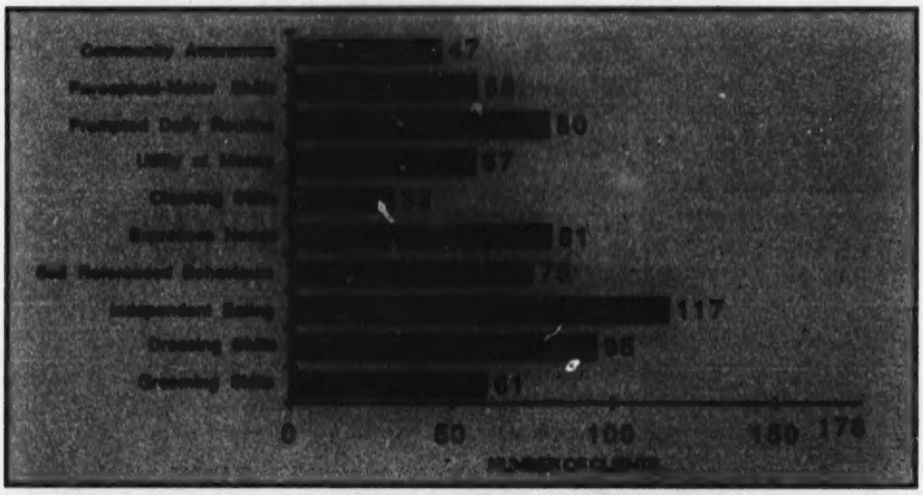

Figure 2.34: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF MAYDAY HILLS RESIDENTS

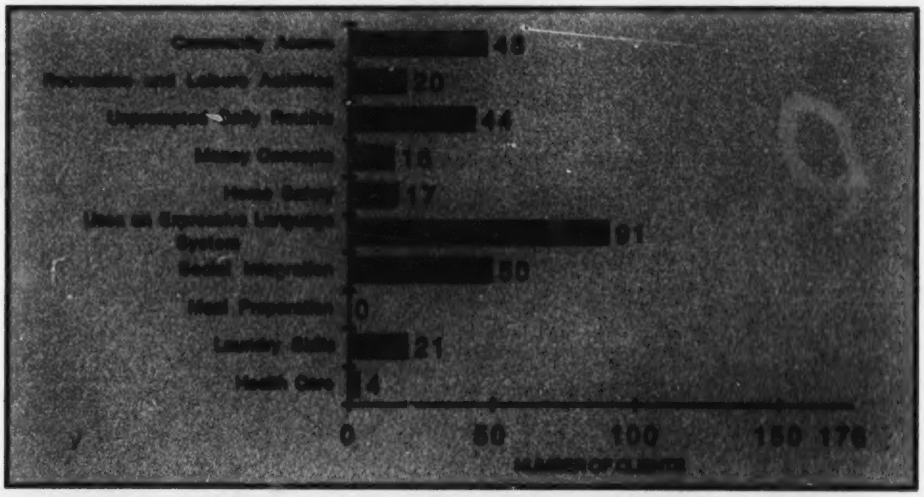

Figure 2.35: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT LIFE OF MAYDAY HILL RESIDENTS

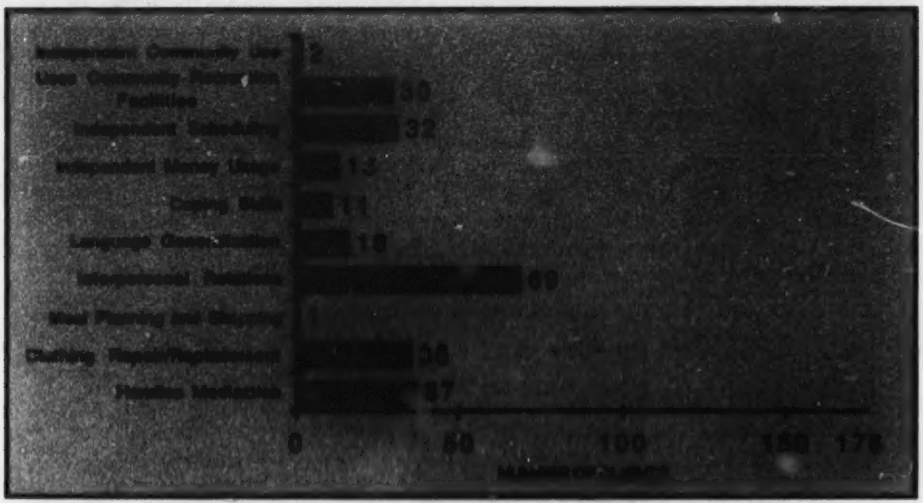

Figure 2.36: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF MAYDAY HILLS RESIDENTS

2.3.4 Profile of Resident Population of Kew Cottages

- **Number and Gender**

At the time of our data collection (June-September 1986) it was reported that 799 people with intellectual disabilities of whom 483 were men and 316 were women lived at Kew Cottages which is located in Inner Eastern Suburbs of Melbourne. 29% (N = 234) of these people had lived in at least one other residential institution during their lifetime.

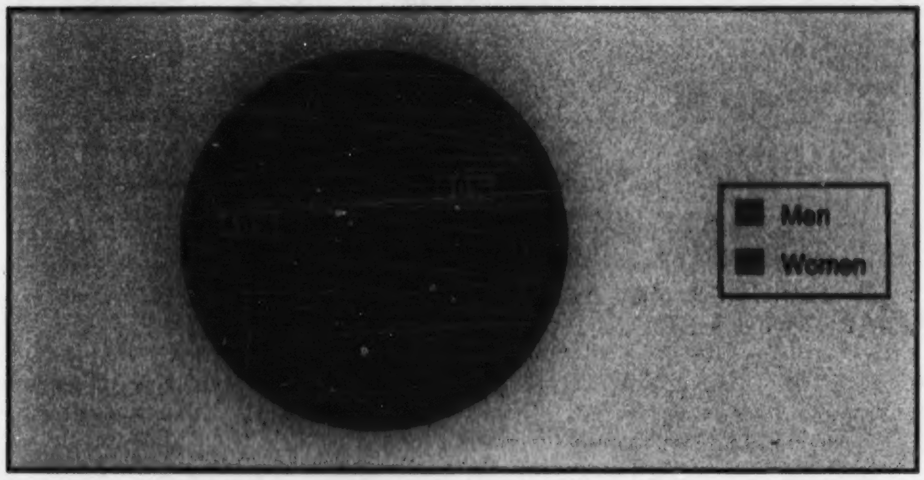

Figure 2.37: GENDER OF PEOPLE WITH INTELLECTUAL DISABILITY RESIDING AT KEW COTTAGES

- **Age Range**

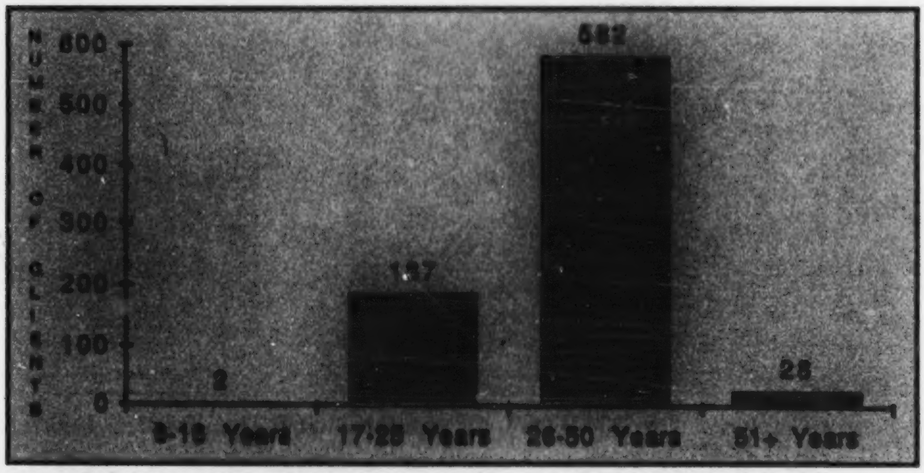

FIGURE 2.38: AGE RANGE OF KEW COTTAGES RESIDENTS CORRECTED TO AUGUST 1988

- **Family Contact**

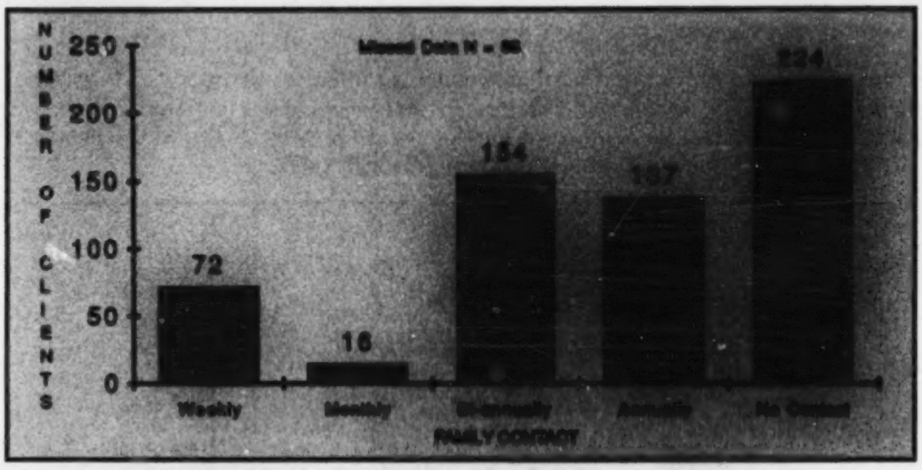

Figure 2.39: FREQUENCY OF CONTACT WITH FAMILIES BY KEW COTTAGES RESIDENTS

As can be seen in figure 2.39, 19% of Kew Cottages residents had contact with their families twice per year, 17% have annual contact, 9% have weekly contact and 2% have contact once per month. 28% have no contact with family members.

Their contact took a number of forms: for 24% of clients this was visits from relatives, with or without an accompanying outing, 23% went home for visits and 13% received telephone calls. (Figure 2.40)

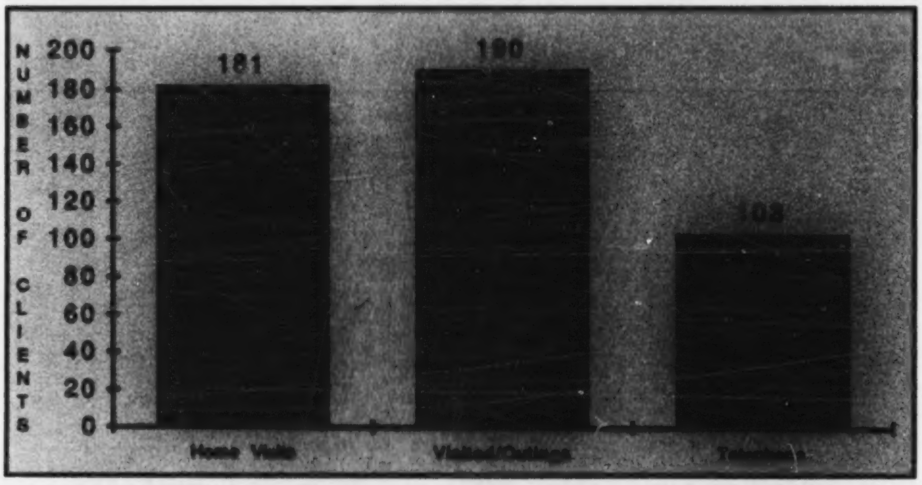

Figure 2.40: TYPE OF CONTACT KEW COTTAGES RESIDENTS HAVE WITH THEIR FAMILIES

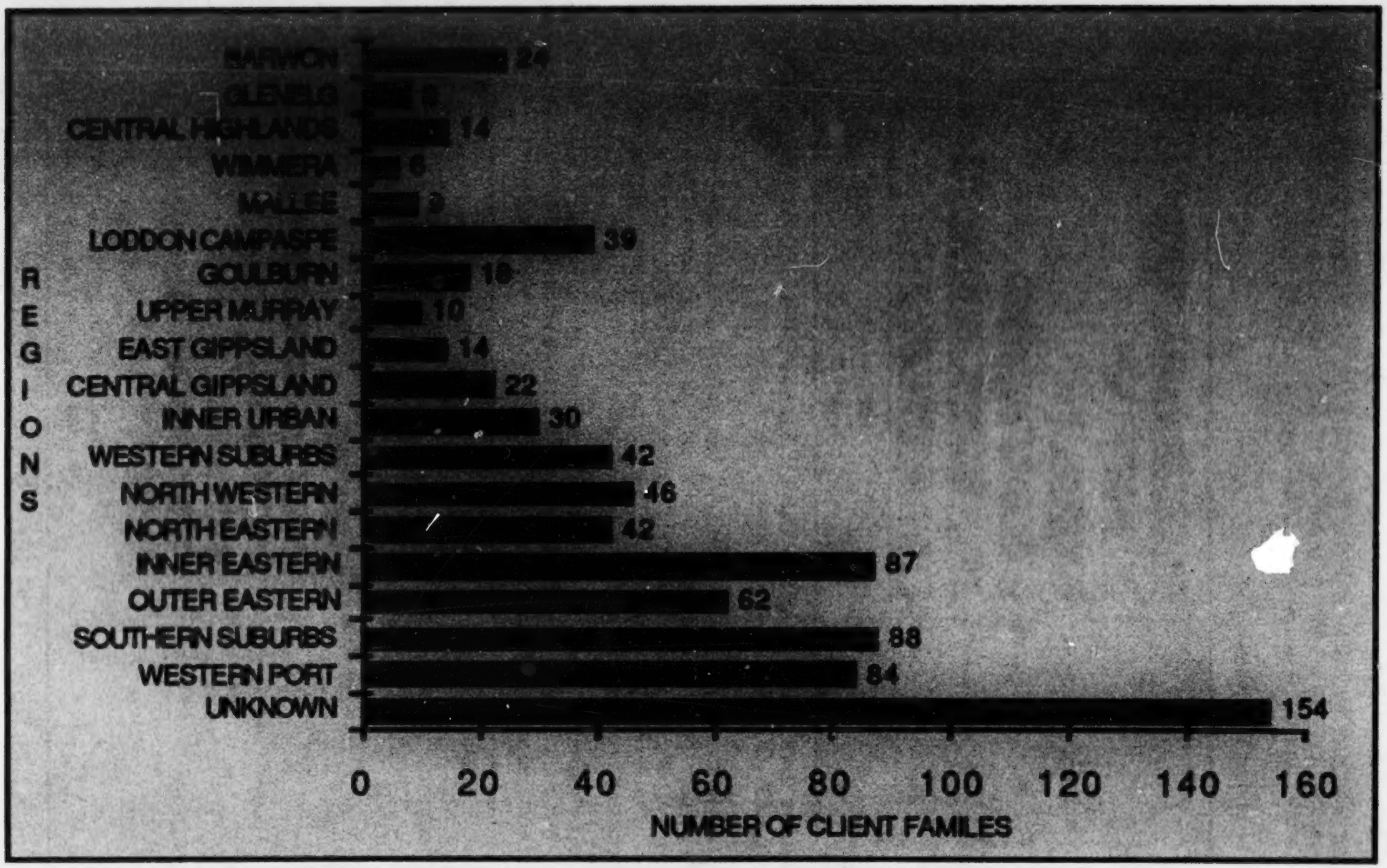

Figure 2.41: LOCATION OF RELATIVES OF KEW COTTAGES RESIDENTS

■ Location of Families

The location of the families is displayed in Figure 2.41. This indicates that the greater proportion of families lived in the Southern Suburbs of Melbourne 11%), the Inner Eastern Suburbs (11%) and Western Port (11%). As shown, 19% of residents had no known family.

■ Secondary Disabilities

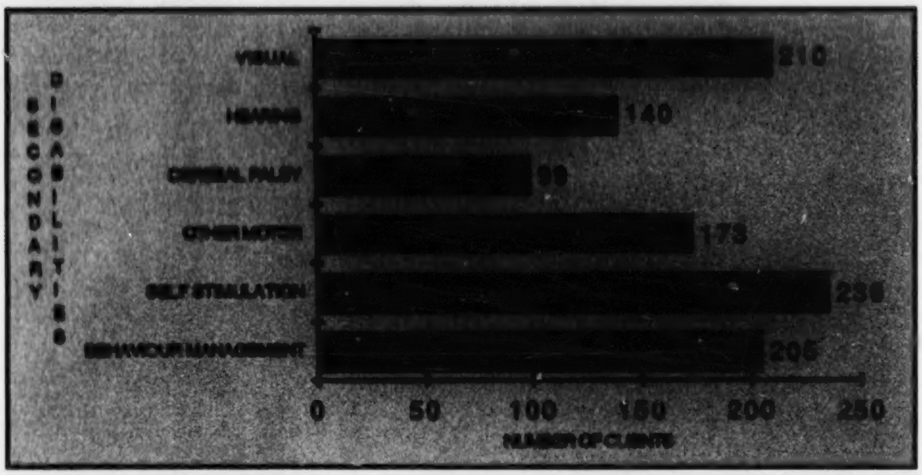

Figure 2.42: SECONDARY DISABILITIES EXPERIENCED BY RESIDENTS OF KEW COTTAGES

As can be seen in Figure 2.43, visual disability was the most prevalent sensory disability experienced by residents of Kew Cottages (26% of all clients). 18% had a substantial hearing loss, 12% have cerebral palsy and 22% have other motor disabilities. 30% exhibited repetitive self-stimulatory or self abusive behaviours and 27% required a behaviour management programme for the social behaviours they displayed in the institutional setting.

Data displayed in Figure 2.43 indicates that there was not any significant relationship between secondary disabilities and social behaviour problems. However, almost half of those people presenting a behaviour management problem also exhibited repetitive self-stimulation.

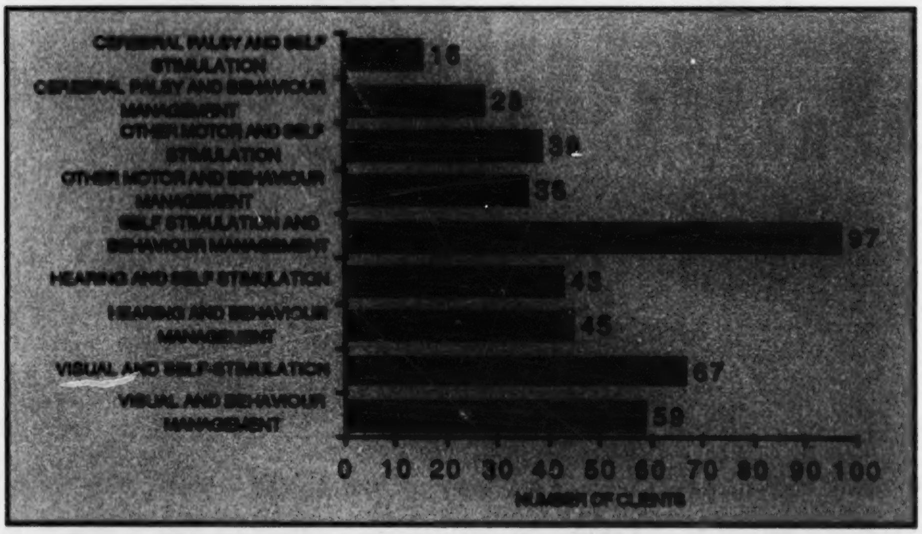

Figure 2.43: NUMBER OF KEW COTTAGES RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO THEIR SECONDARY DISABILITIES

▪ Multiple Disabilities

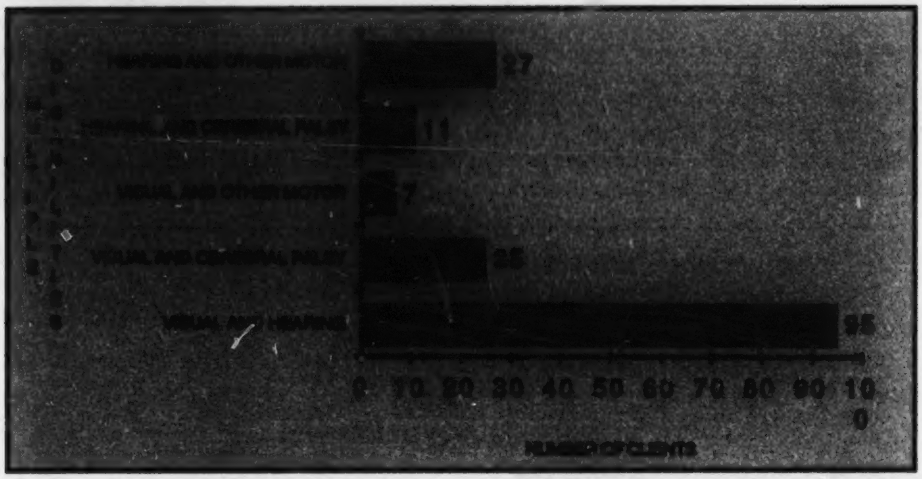

Figure 2.44: NUMBER OF KEW COTTAGES RESIDENTS EXPERIENCING MULTIPLE DISABILITIES

As can be seen in figure 2.44, the most common combination of disabilities was that of hearing and visual disabilities. This indicates that 68% of all people with a diagnosed hearing disability at Kew Cottages also had a significant visual disability.

▪ Medical Conditions

The medical conditions experienced by people living at Kew Cottages are summarized in Figure 2.45. When this data is compared with the Statewide Training Centre profile (figure 2.9) it is revealed that slightly more Kew Cottages people have Grand Mal epilepsy (33% compared with 27% statewide) and that slightly less people have a diagnosed psychiatric illness (5% compared with 8% statewide).

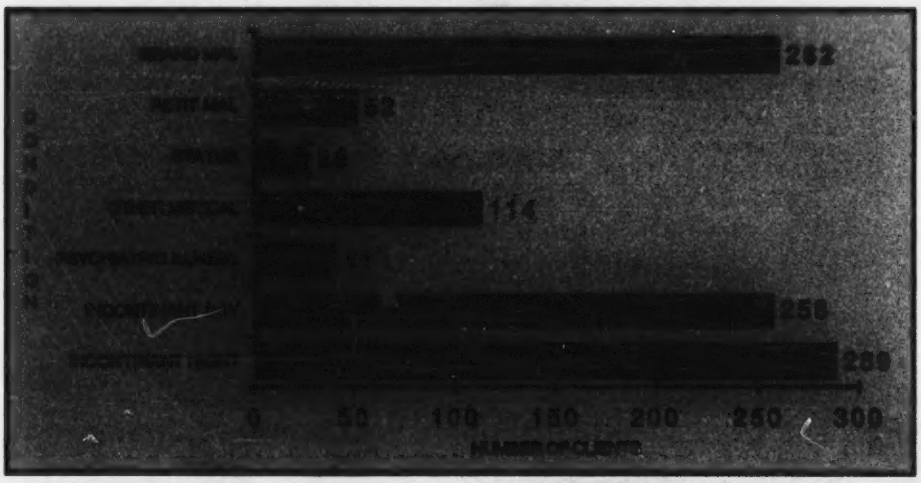

Figure 2.45: MEDICAL CONDITIONS OF RESIDENTS OF KEW COTTAGES

▪ Skill Strengths in Activities of Ordinary Daily Community Life

The data pertaining to the reported basic skills actually performed independently by Kew Cottages residents in the course of their daily lives in the institutional setting is displayed in figure 2.48. This indicates that, compared with the Statewide Training Centre population data presented in figure 2.10, fewer Kew residents independently engaged in all discrete basic skills other than expressing needs, which is slightly higher (64% compared with 59% statewide). This trend is consistent across independence in skills required for semi-independent living (figure 2.47) and those necessary for an independent lifestyle (figure 2.48).

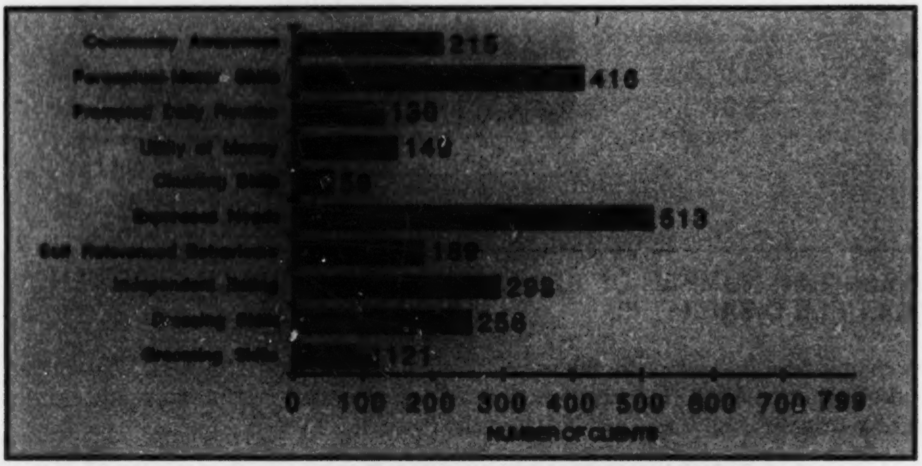

Figure 2.46: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF KEW COTTAGES RESIDENTS

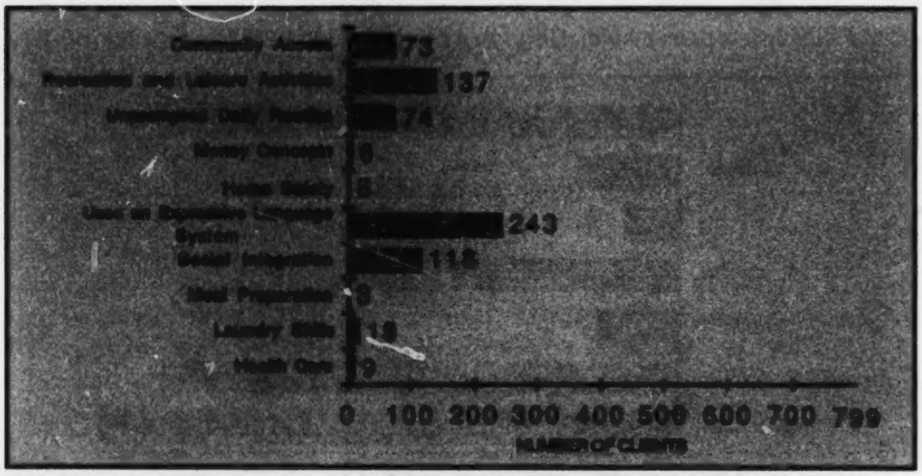

Figure 2.47: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF KEW COTTAGES RESIDENTS

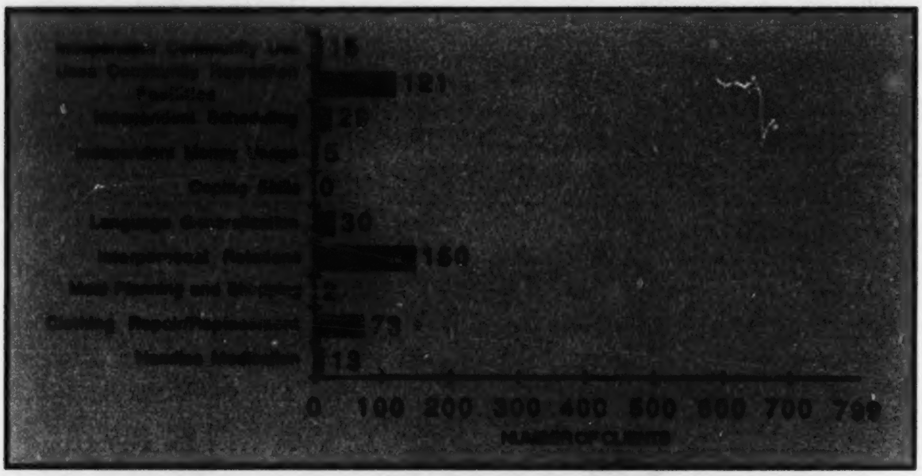

Figure 2.48: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF KEW COTTAGES RESIDENTS

2.3.5 Profile of Resident Population of St Gabriel's Training Centre

▪ Number and Gender

During June-September 1986 our data indicates that 41 people, 30 males (73%) and 11 (27%) females, with intellectual disabilities lived at St. Gabriel's Centre in Balwyn and that 18 of them had also lived in other residential institutions before moving to St. Gabriel's.

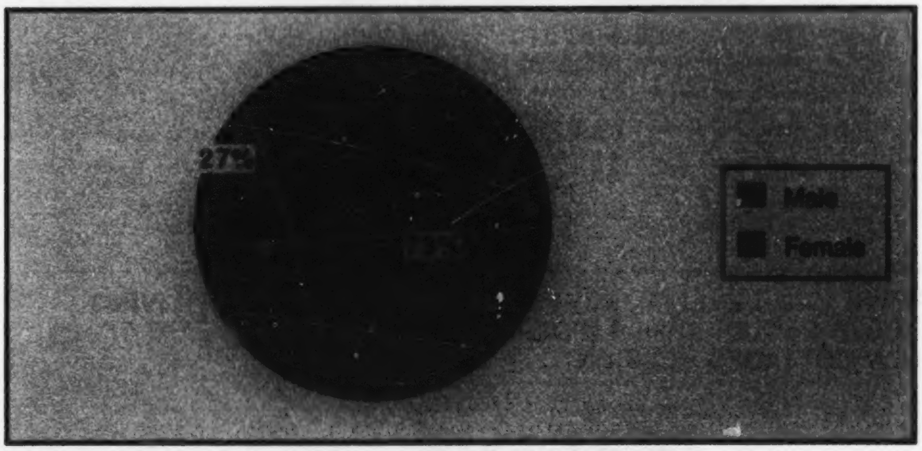

Figure 2.49: GENDER OF ST. GABRIEL'S RESIDENTS

▪ Age Range

As can be seen in figure 2.50, all people living at St. Gabriel's were under the age of 25 years; 29% were aged between 17 and 25 years, the greater majority, 66% were between the ages of 6 and 16 years and two are under five years. This data is corrected to August 1988.

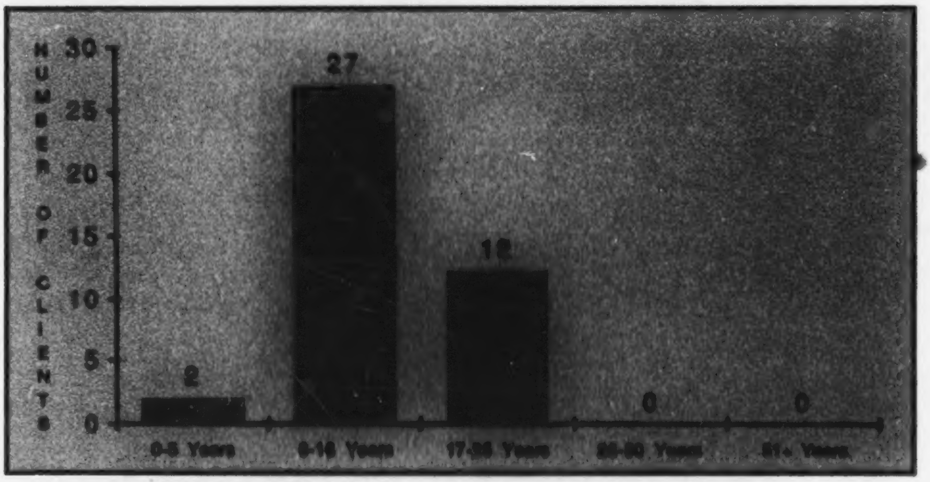

Figure 2.50: AGE RANGE OF ST. GABRIEL'S RESIDENTS, CORRECTED TO AUGUST 1988

- **Family Contact**

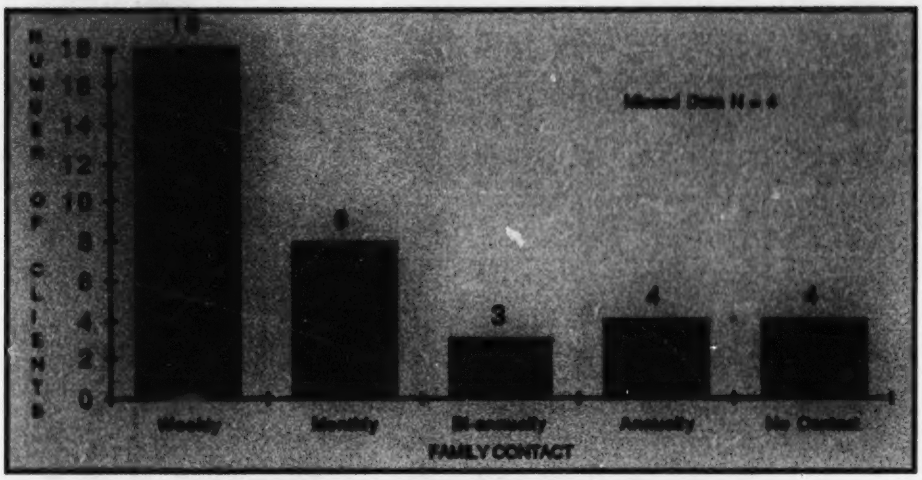

Figure 2.51: FREQUENCY OF CONTACT WITH FAMILY BY ST. GABRIEL'S RESIDENTS

Our data (Figure 2.51) indicates that most of the young people living at St. Gabriel's had contact with their families and for 44%, this was on a weekly basis. Only 10% had no reported family contact.

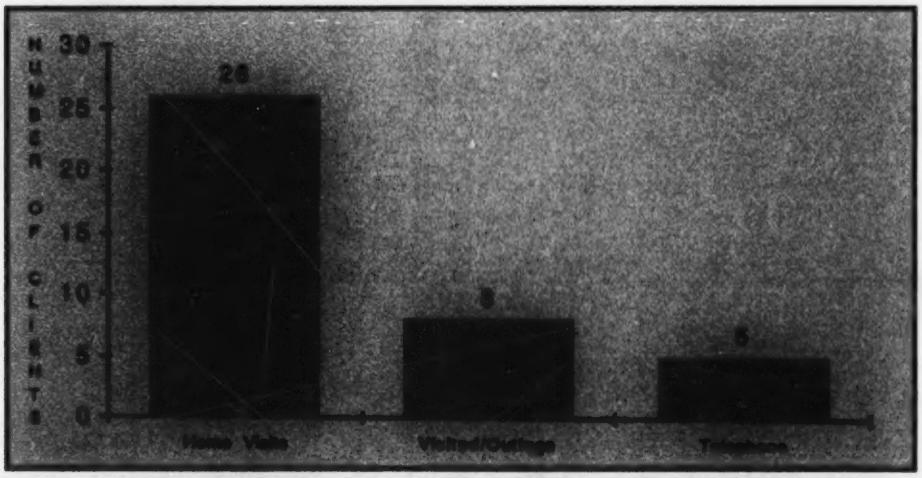

Figure 2.52: TYPE OF CONTACT ST. GABRIEL'S RESIDENTS HAD WITH THEIR FAMILIES

The type of contact is shown in Figure 2.52, and indicates that most (63%) residents went home for visits.

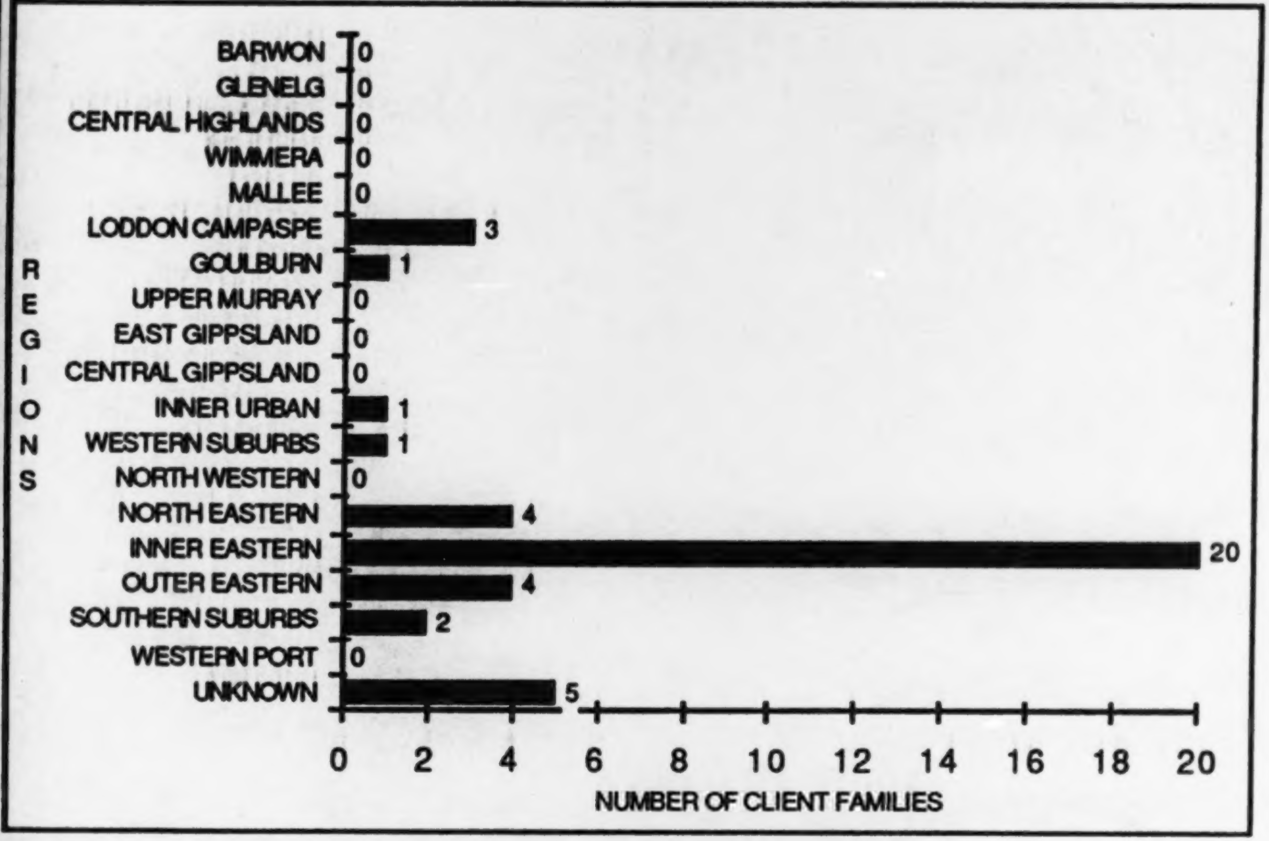

Figure 2.53: LOCATION OF RELATIVES OF ST. GABRIEL'S RESIDENTS

- **Location of Families**

Data presented in Figure 2.53 shows that 50% of all St. Gabriel's residents had families in the Inner Eastern Suburbs where St. Gabriel's itself is located. The whereabouts of 12% of families was not known.

- **Secondary Disabilities**

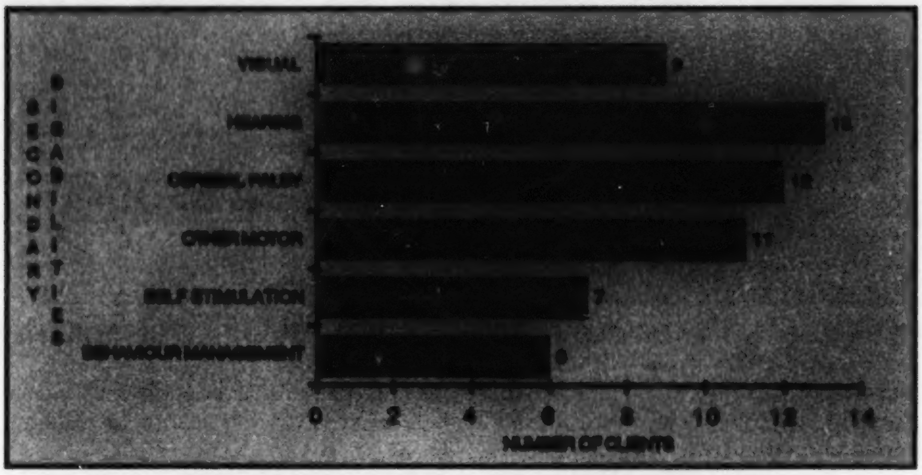

Figure 2.54: SECONDARY DISABILITIES EXPERIENCED BY ST. GABRIEL'S RESIDENTS

It was reported that 32% of people living at St. Gabriel's had a significant hearing disability, 29% had cerebral palsy, 22% had a visual disability and 27% had some other form of motor disability. 17% exhibited repetitive self-stimultory behaviours in the institutional setting and 15% required behaviour management programmes for socially unacceptable behaviour patterns. Data presented in figure 2.58 indicates that few people with secondary sensory and/or motor disabilities engaged in unacceptable social behaviour patterns (figure 2.55)

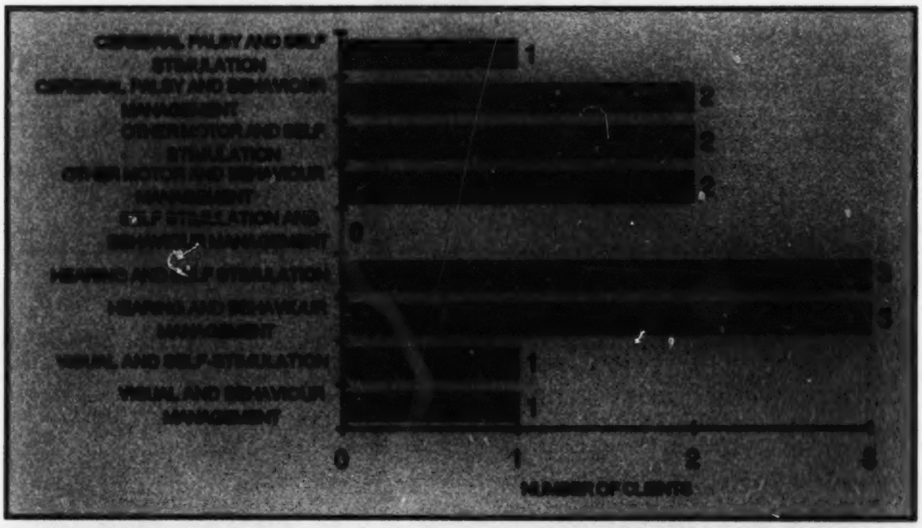

Figure 2.55: NUMBER OF ST. GABRIEL'S RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO THEIR SECONDARY DISABILITIES

- **Multiple Disabilities**

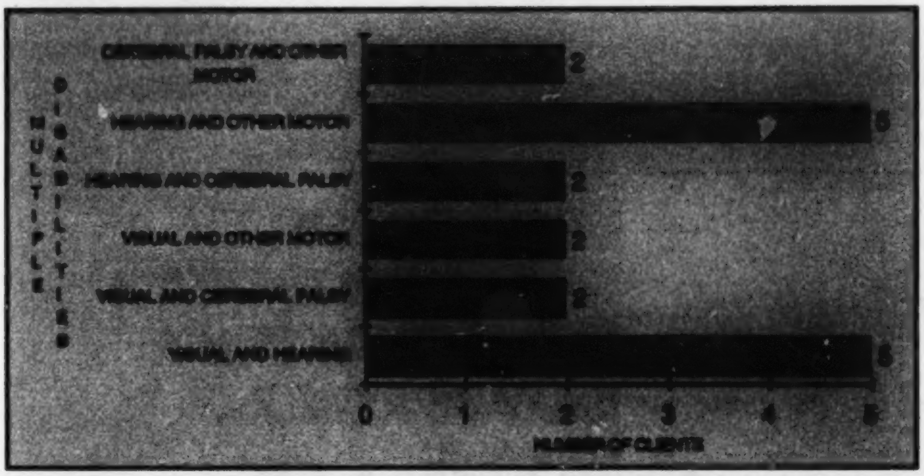

Figure 2.56: ST. GABRIELS RESIDENTS WITH MULTIPLE DISABILITIES

Data presented in Figure 2.56 indicates that a small proportion of these people experienced multiple disabilities, with the most common combination being visual and hearing disabilities, (12%) and hearing and other motor disabilities (12%).

- **Medical Conditions**

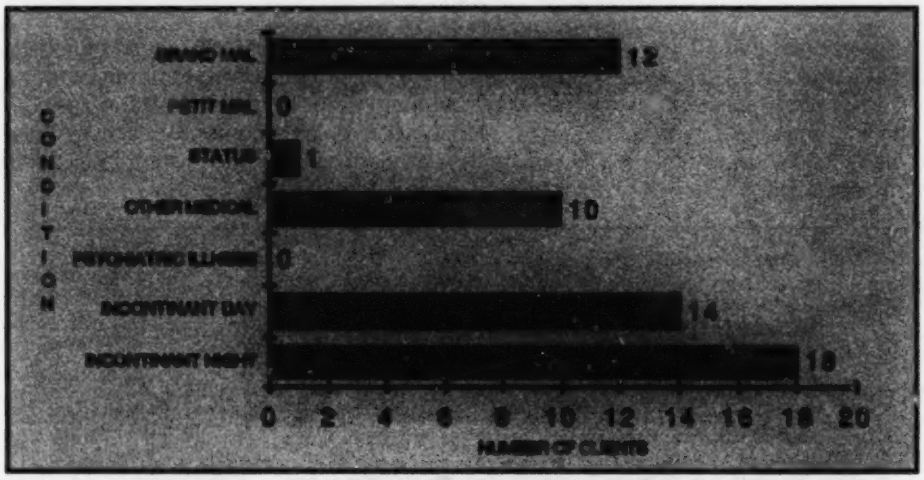

Figure 2.57: MEDICAL CONDITIONS OF ST. GABRIEL'S RESIDENTS

As displayed in Figure 2.57, incontinence at night (43%) and during the day (34%) were the most prevalent medical disorders among the St. Gabriel's resident population. 29% had grand mal epilepsy and 24% of residents had some other form of medical condition.

- **Skill Strengths in Activities of Ordinary Daily Life**

The reported basic skills actually performed independently by the young people living at St. Gabriel's Centre during their daily lives in the institutional setting are summarized in figure 2.58. When this data is compared with the Statewide profile in figure 2.10, it is evident that a much smaller proportion of St. Gabriel's residents was independent in all basic skills other than community awareness (59% compared with 39% statewide).

This trend is consistent across independence in the skills required for semi-independent living (figure 2.59) and those required for an independent lifestyle (figure 2.60).

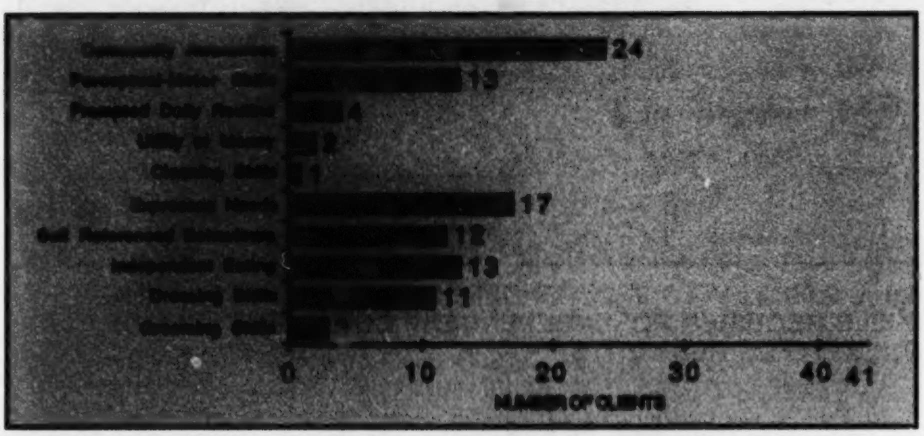

Figure 2.58: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF ST. GABRIEL'S RESIDENTS

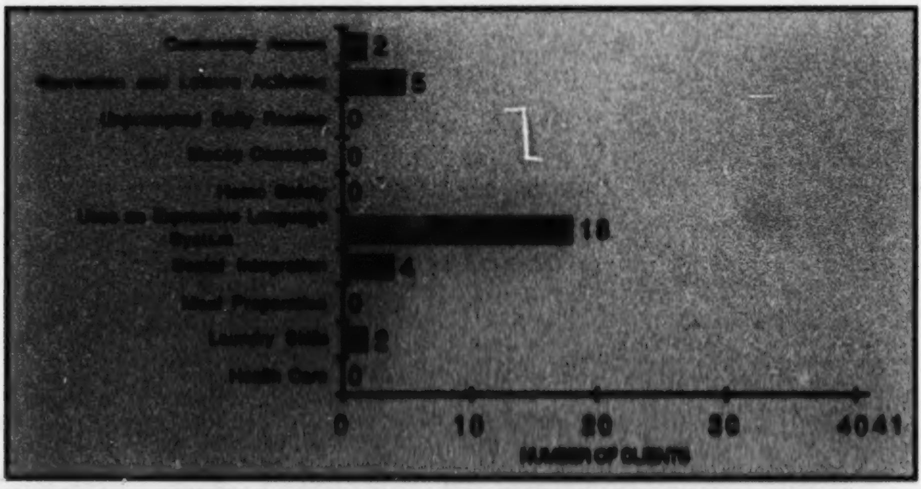

Figure 2.59: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF ST. GABRIELS RESIDENTS

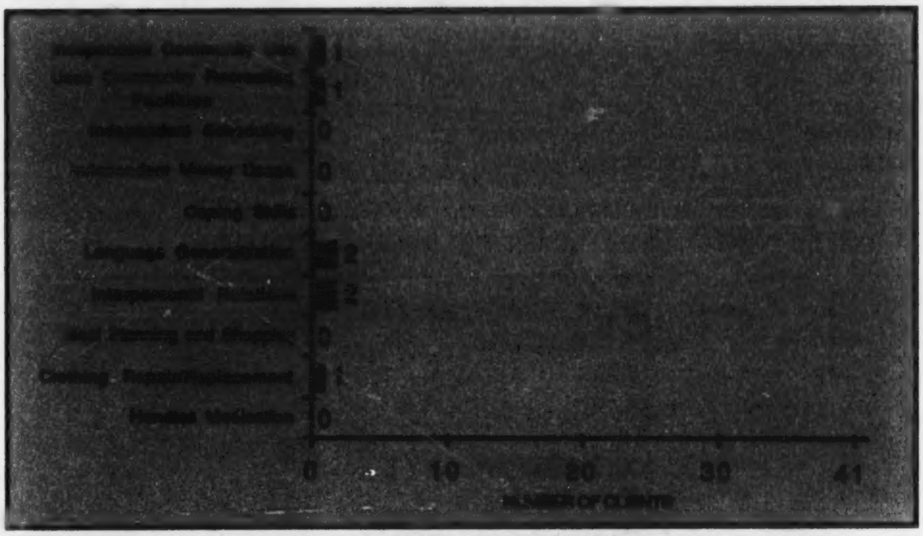

Figure 2.60: LEVEL3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF ST. GABRIEL'S RESIDENTS

2.3.6 Profile of Resident Population of Janefield Training Centre

▪ Number and Gender

During June-September 1986 there were 427 people, 162 of whom were men and 265 were women, living at Janefield Training Centre, in Bundoora. According to data supplied to us, 160 (37%) had also lived at some other residential institution before taking up residence at Janefield.

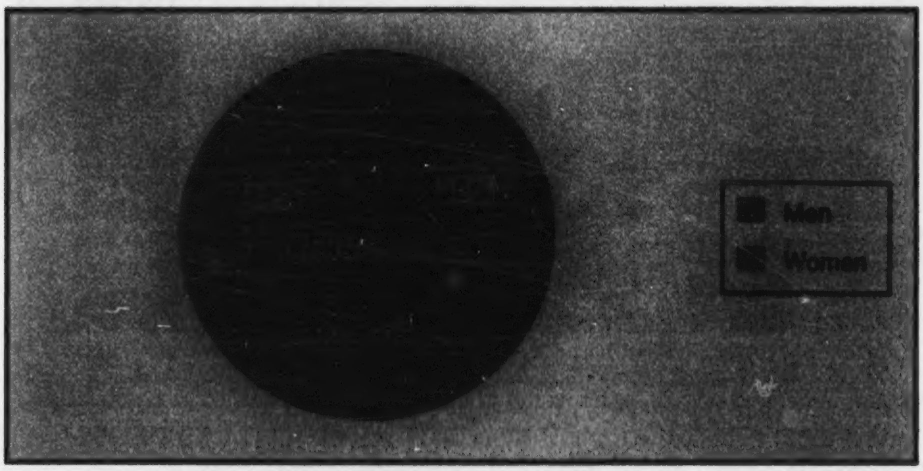

Figure 2.61: GENDER OF PEOPLE WITH INTELLECTUAL DISABILITIES LIVING AT JANEFIELD TRAINING CENTRE

▪ Age Range

As can be seen in Figure 2.62, 57% of people living at Janefield were mature adults (26-50 years) 33% were young adults, 5% were over 51 years and 6% were children. These ages are corrected to August 1988.

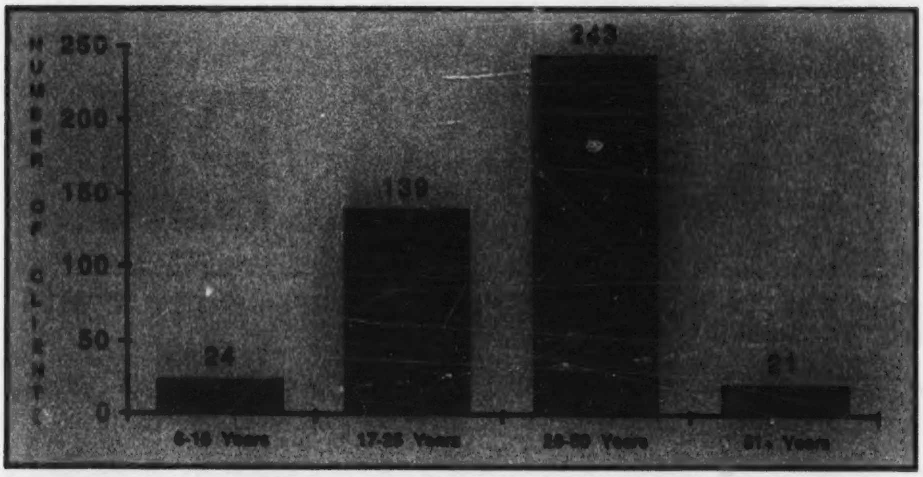

Figure 2.62: AGE RANGE OF JANEFIELD RESIDENTS CORRECTED TO AUGUST 1988

Family Contact

As indicated in figure 2.63, 7% of people living at Janefield had contact with their families on a weekly basis, 21% had monthly contact, 26% had contact twice per year, 13% once per year. It was reported that 27% had no family contact.

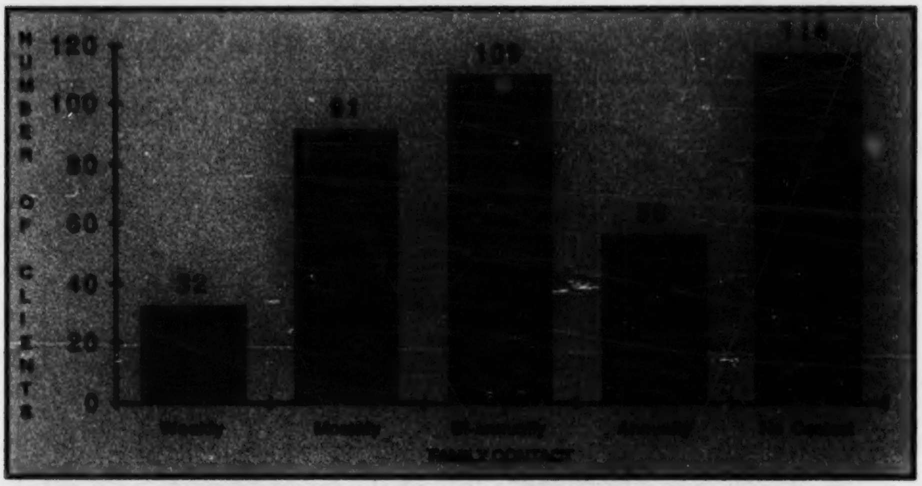

Figure 2.63: FREQUENCY OF CONTACT JANEFIELD RESIDENTS HAD WITH THEIR FAMILIES

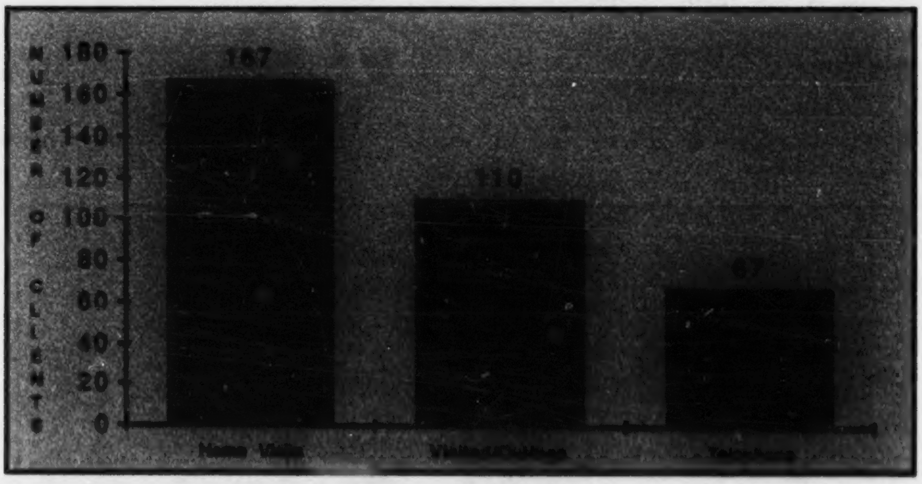

Figure 2.64: TYPE OF CONTACT JANEFIELD RESIDENTS HAD WITH THEIR FAMILIES

The type of contact residents had varied from visits to their family home (39% of residents), visits by relatives to the institution (20%) and/or telephone calls (16%). (See Figure 2.64)

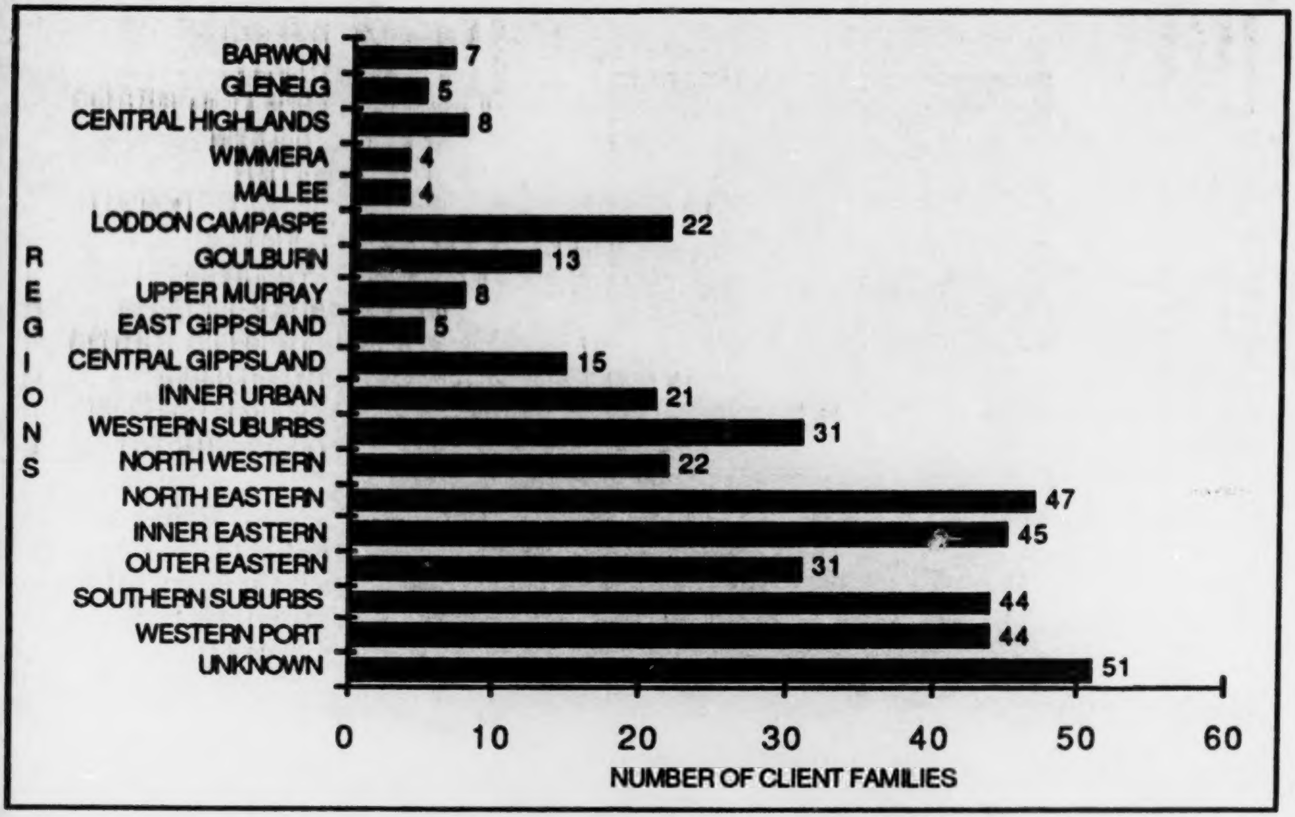

Figure 2.65: REGIONS IN WHICH RELATIVES OF JANEFIELD RESIDENTS LIVE

▪ Location of Families

Data presented in figure 2.69 shows that the families of people living at Janefield were distributed across the state, with the greatest numbers in the North Eastern Suburbs (19% of families) where Janefield Centre itself is located, the Inner Eastern Suburbs (18%) Southern Suburbs (18%) and Western Port (18%). As shown, it was reported that the whereabouts of the families of 21% of residents was not known.

▪ Secondary Disabilities

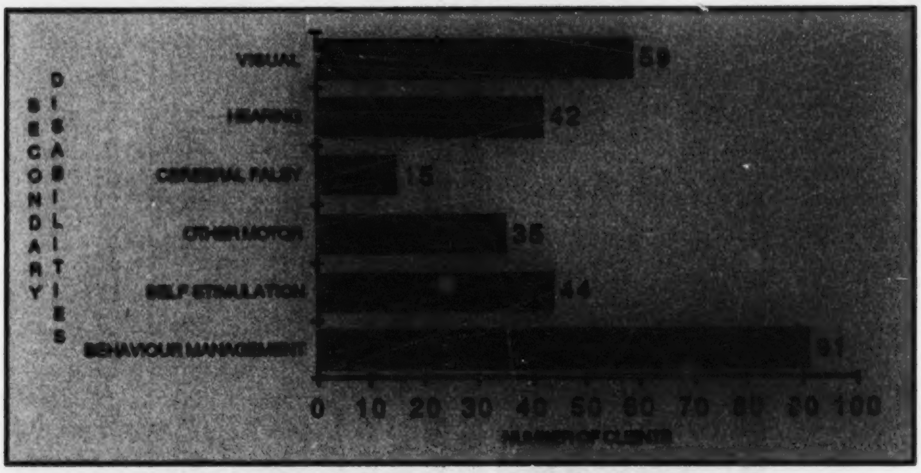

Figure 2.66: SECONDARY DISABILITIES EXPERIENCED BY JANEFIELD RESIDENTS

As indicated in Figure 2.66, 24% of the people living at Janefield had a visual disability and 17% had a significant hearing loss, 44% exhibited repetitive self stimulatory/self abusive behaviours on a regular basis and 37% required behaviour management programmes for social behaviours exhibited in the institutional setting.

Data presented in Figure 2.67 indicates that there was little relationship between secondary disabilities and those social behaviours regarded as unacceptable.

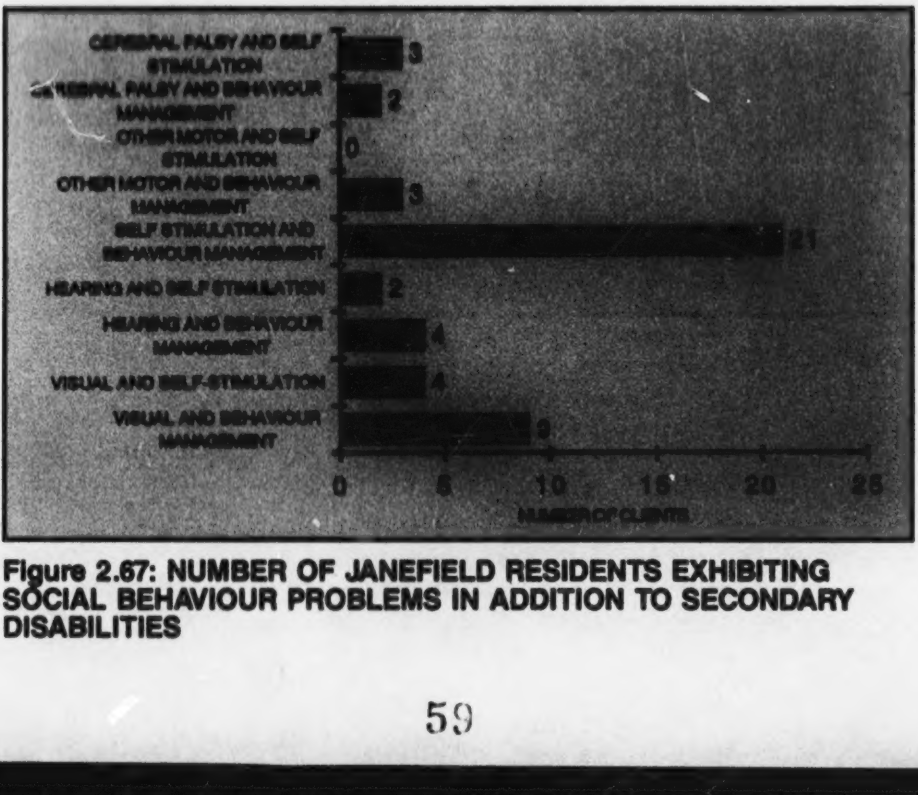

Figure 2.67: NUMBER OF JANEFIELD RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO SECONDARY DISABILITIES

▪ Multiple Disabilities

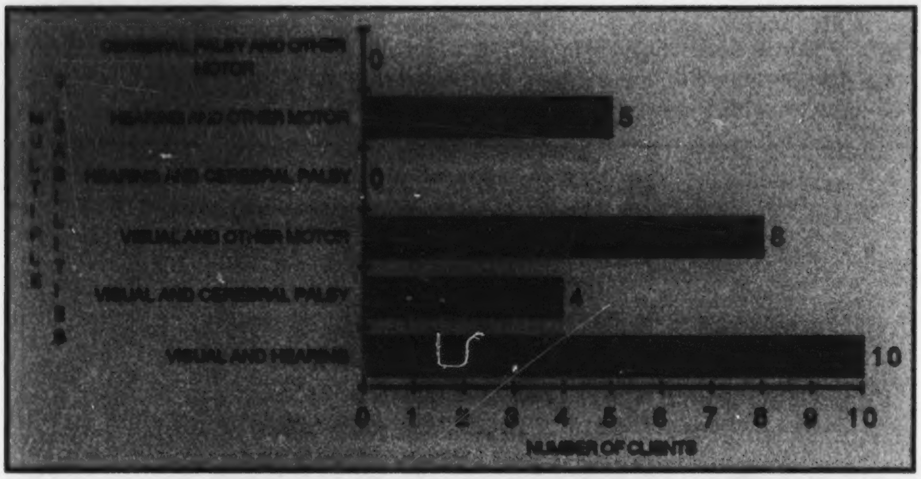

Figure 2.68: NUMBER OF JANEFIELD RESIDENTS EXPERIENCING MULTIPLE DISABILITIES IN ADDITION TO INTELLECTUAL DISABILITY

Data presented in Figure 2.68 indicates that few people living at Janefield had multiple disabilities.

▪ Medical Conditions

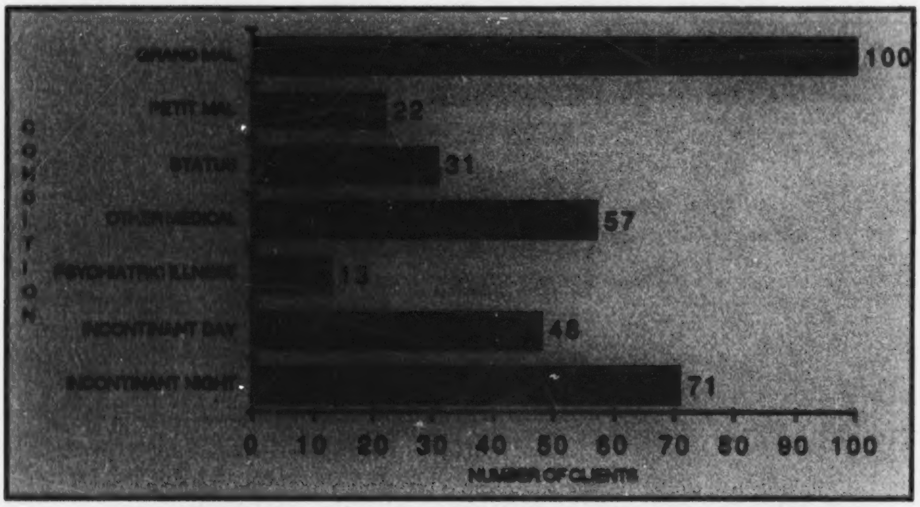

Figure 2.69: MEDICAL CONDITIONS OF JANEFIELD RESIDENTS

The medical conditions experienced by people living at Janefield Training Centre are summarised in figure 2.69. This data indicates that fewer people living at Janefield have medical conditions than the average for the Training Centre population (figure 2.9) with one exception:—, it was reported that a larger proportion of Janefield clients experienced status epilepticus (7% compared with 3% statewide).

▪ Skill Strengths in Activities of Ordinary Daily Life

The reported basic skills actually performed independently by Janefield residents in the course of their daily lives are summarized in figure 2.70. When this data is compared with the Statewide Training Centre data presented in figure 2.10, it is revealed that many more Janefield residents performed these discrete behaviours independently than the Statewide average.

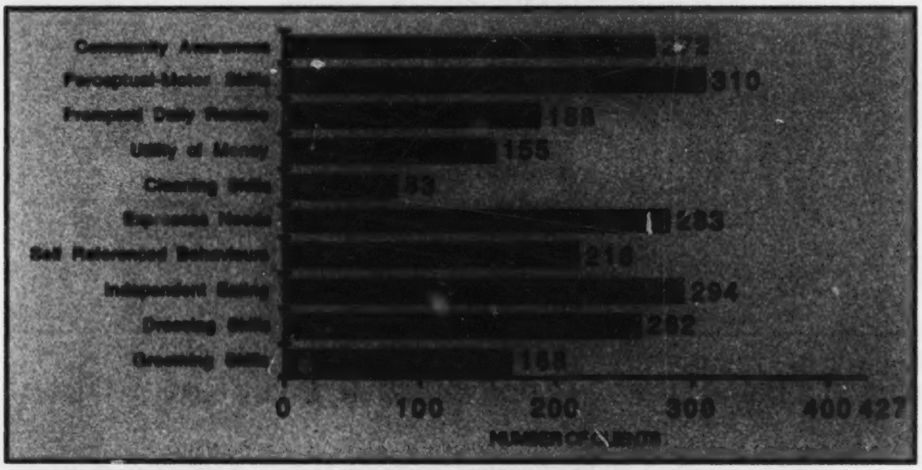

Figure 2.70: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF JANEFIELD RESIDENTS

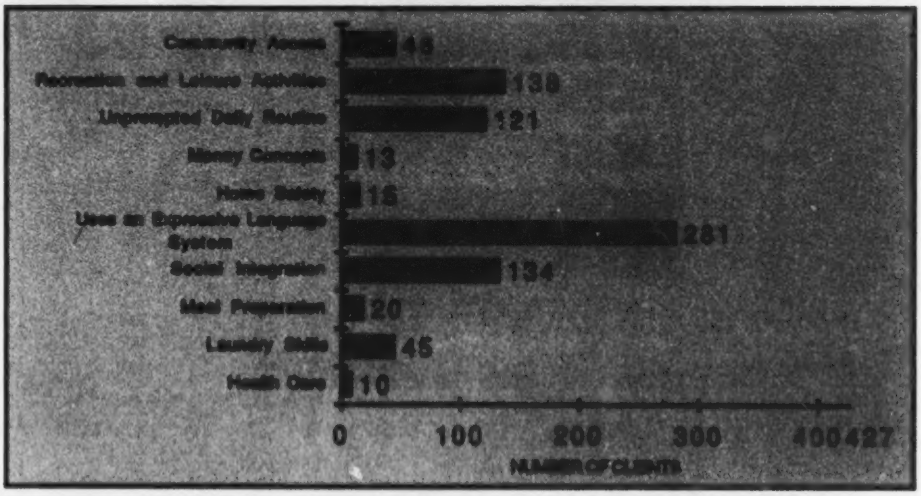

Figure 2.71: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF JANEFIELD RESIDENTS

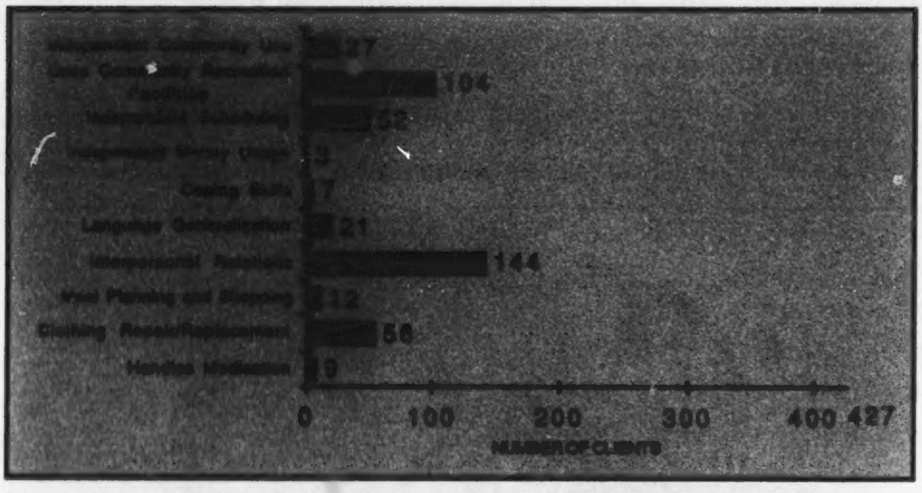

Figure 2.72: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF JANEFIELD RESIDENTS

Data presented in Figure 2.71 indicates that the number of Janefield clients who independently performed those behaviours required for semi-independent living is also slightly higher than the Statewide pattern and that this trend also covers those discrete behaviours required for independent community life (figure 2.74).

2.3.7 Profile of Population of Kingsbury Training Centre

▪ Number and Gender

Our data indicates that, in June-September 1986, there were 80 people with intellectual disabilities living at Kingsbury Training Centre in Bundoora, of whom 48 were men and 32 were women. Of these, 64 had lived in at least one other residential institution before moving to Kingsbury.

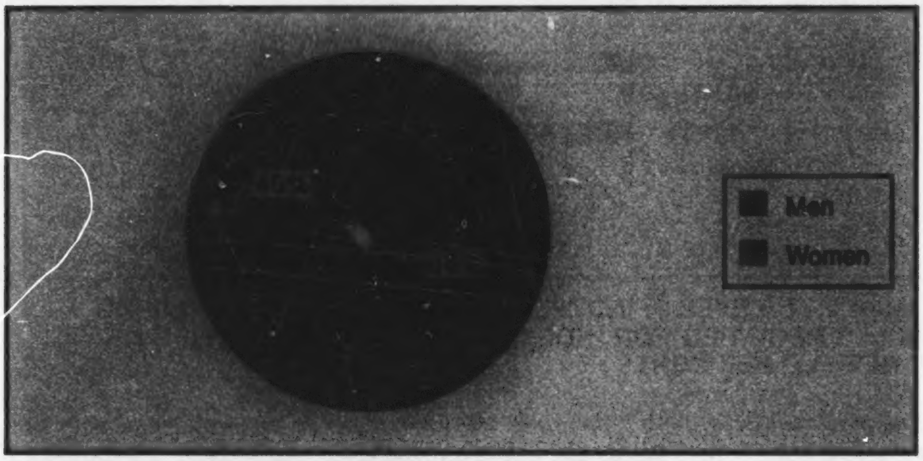

Figure 2.73: GENDER OF PEOPLE WITH INTELLECTUAL DISABILITIES LIVING AT KINGSBURY TRAINING CENTRE

▪ Age Range

As indicated in figure 2.74, our data shows that all people living at Kingsbury were between the ages of 17 and 50 years, with 68% aged 17—25 years. These figures are corrected to August 1988.

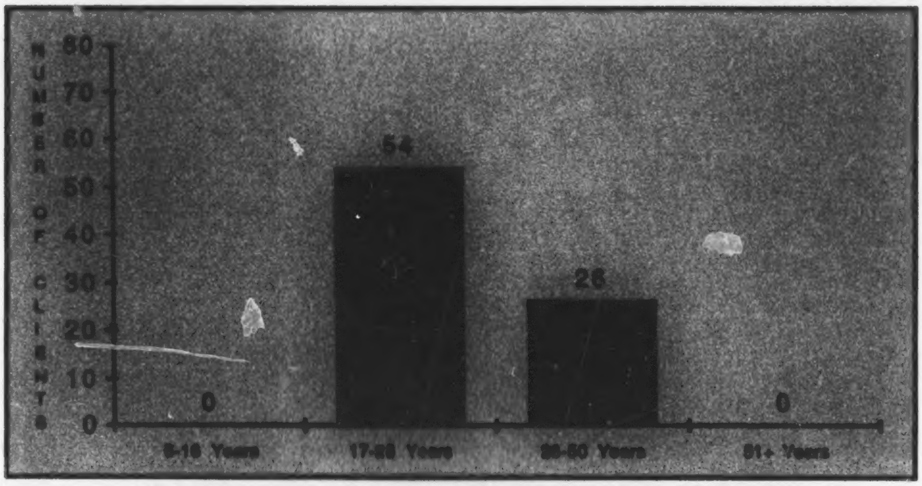

Figure 2.74: AGE RANGE OF KINGSBURY TRAINING CENTRE RESIDENTS CORRECTED TO AUGUST 1988

■ Family Contact

Our data shows that 91% of Kingsbury residents had contact with their families: for 1% this was on a weekly basis, for 28% it was on a monthly basis, 21% had contact twice per year and 16% had annual contact. As displayed in figure 2.75, 9% had no contact with their families. The data shown in figure 2.75 indicates that the most usual type of contact was visits to the family home.

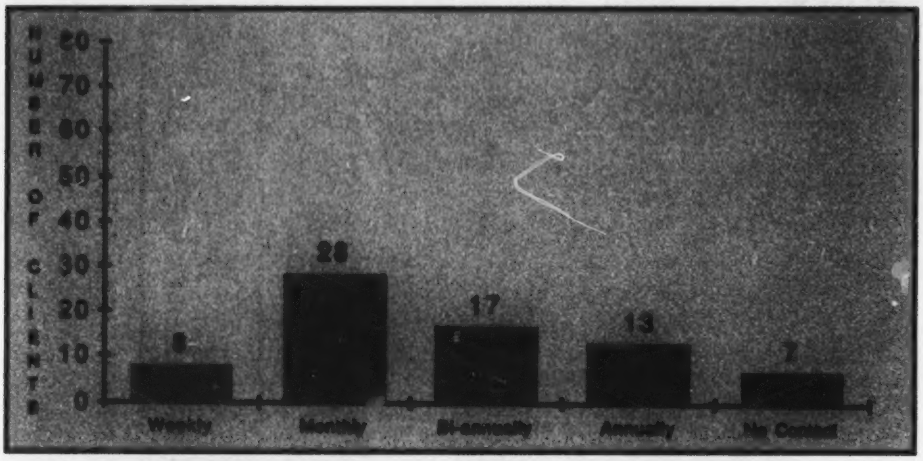

Figure 2.75: FREQUENCY OF CONTACT WITH FAMILIES BY KINGSBURY RESIDENTS

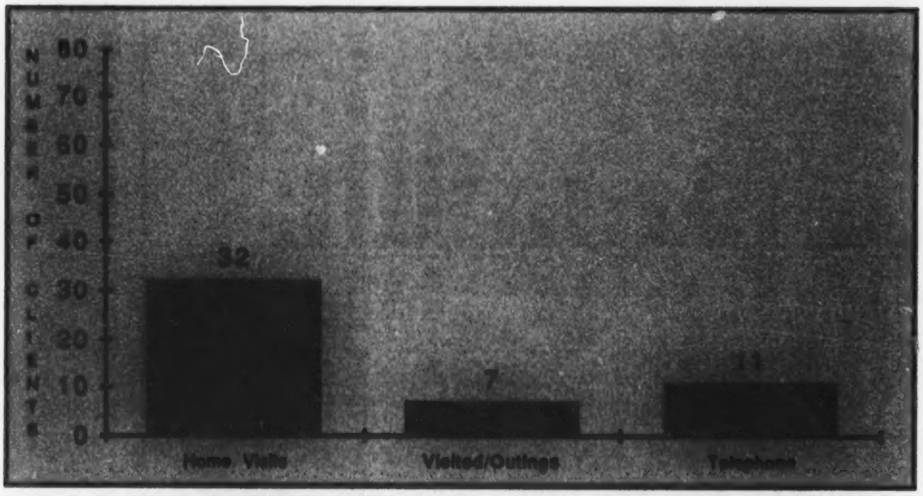

Figure 2.76: TYPE OF FAMILY CONTACT KINGSBURY RESIDENTS HAD WITH THEIR FAMILIES

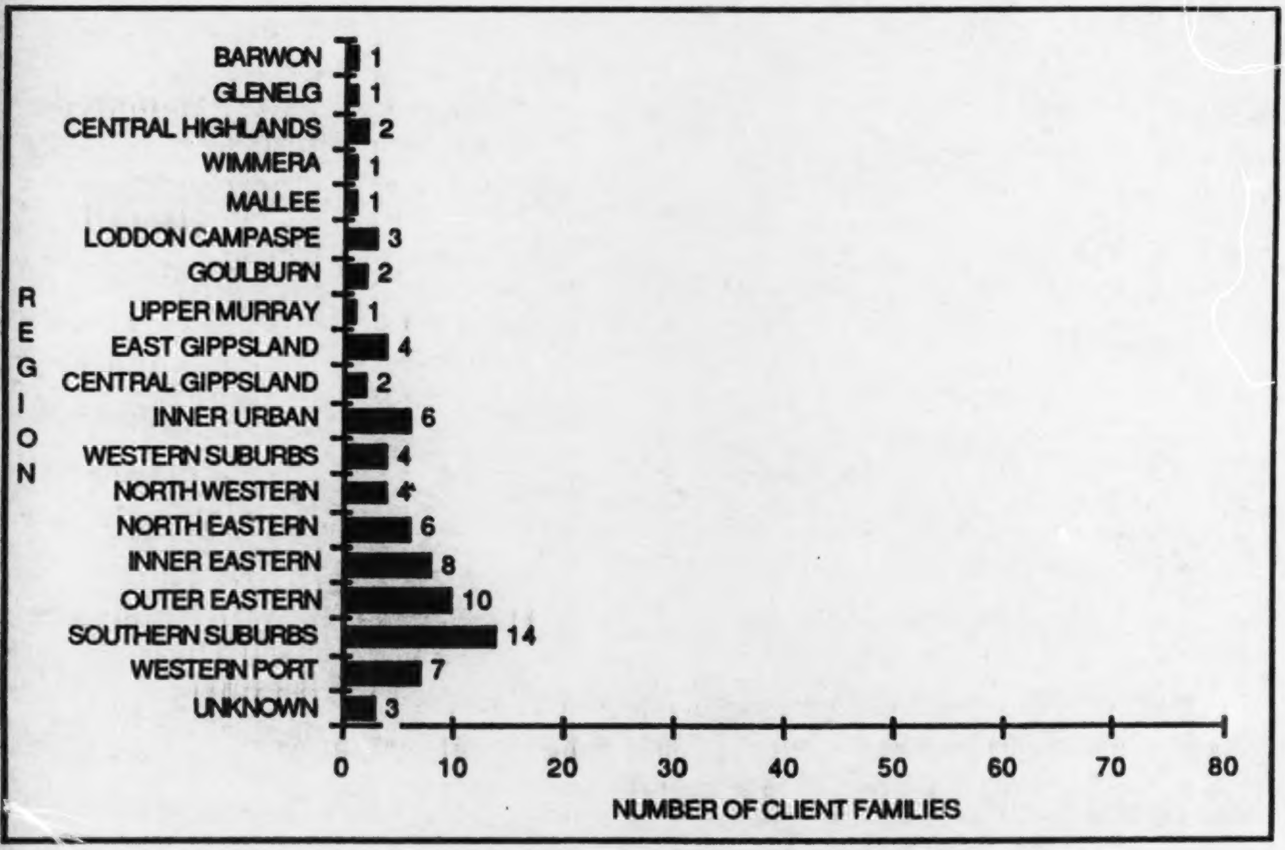

Figure 2.77: REGIONS IN WHICH RELATIVES OF KINGSBURY RESIDENTS LIVE

- **Location of Families**

The families of Kingsbury residents were distributed across all Regions, with the largest number being located in the Southern Suburbs of Melbourne (see Figure 2.77).

- **Secondary Disabilities**

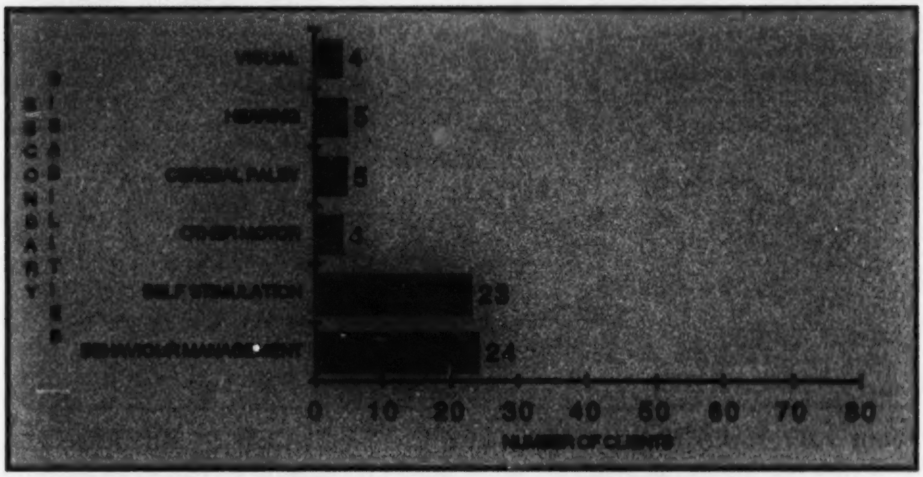

Figure 2.78: SECONDARY DISABILITIES EXPERIENCED BY KINGSBURY RESIDENTS

Data presented in figure 2.78 indicates that very few people living at Kingsbury had secondary disabilities, however 30% displayed social behaviours in the institutional setting which required a behaviour management programme and 30% also engaged in self-stimulatory/self abusive behaviours.

Our data shows that nearly half of those engaging in self-stimulatory behaviours also required a behaviour management problem (Figure 2.79).

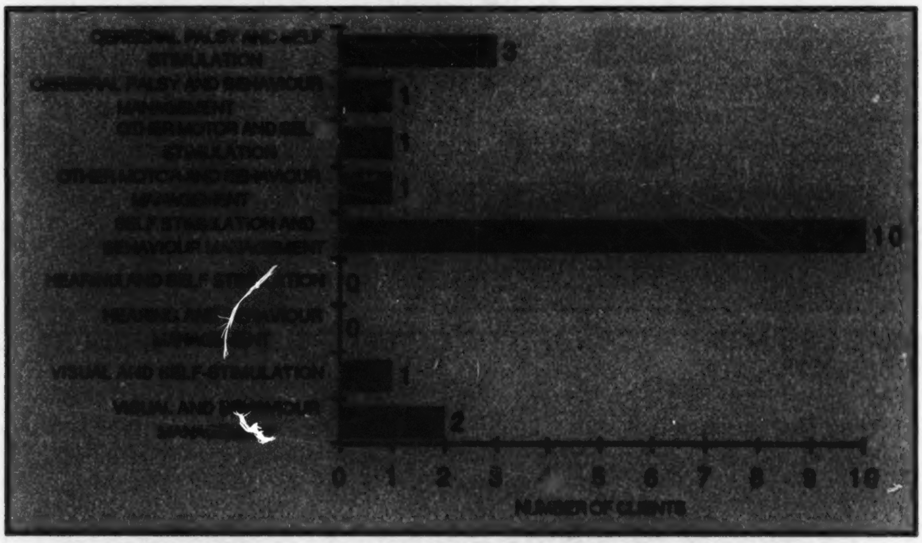

Figure 2.79: NUMBER OF KINGSBURY RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO SECONDARY DISABILITIES

▪ Multiple Disabilities

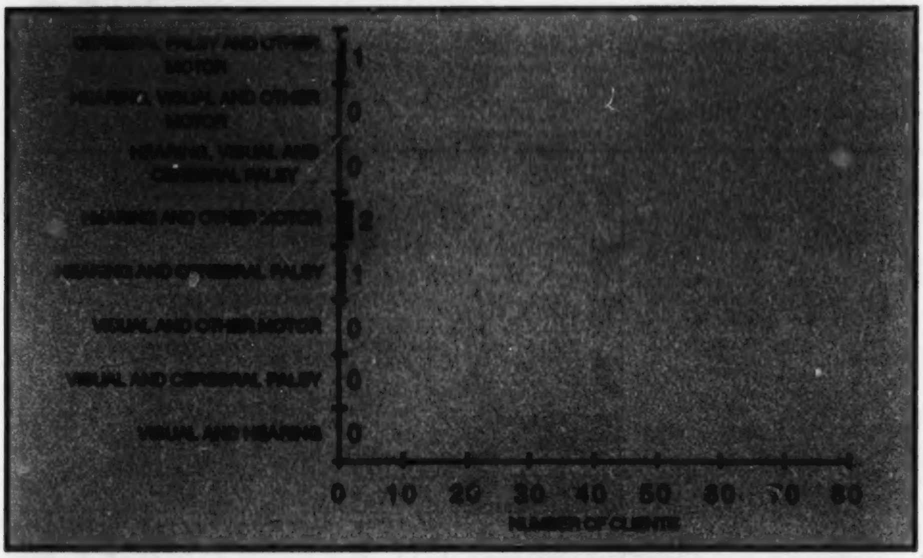

Figure 2.80: MULTIPLE DISABILITIES EXPERIENCED BY KINSBURY RESIDENTS

As shown in figure 2.80, only 4 people living at Kingsbury had multiple disabilities.

▪ Medical Conditions

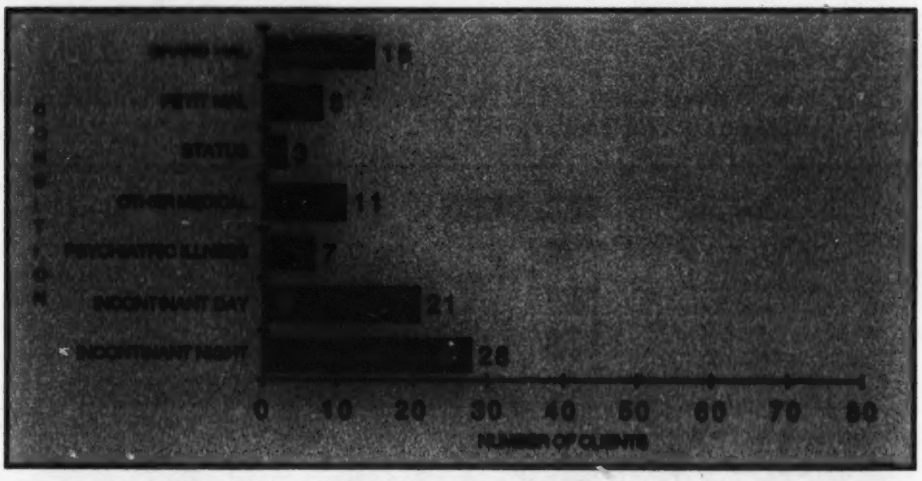

Figure 2.81: MEDICAL CONDITIONS EXPERIENCED BY KINGSBURY RESIDENTS

Data presented in figure 2.81 shows that the most common medical condition was incontinence which affected 35% of people at night and 26% during the day; 19% had grand mal epilepsy.

- **Skill Strengths in Activities of Ordinary Daily Life**

The reported basic skills actually performed by the residents of Kingsbury during their everyday lives are summarized in figure 2.82. This indicates that, when compared with the Statewide data presented in Figure 2.10, fewer Kingsbury residents engage in all of these discrete skill areas, except that slightly more regularly dressed themselves without assistance. In terms of expressing needs, 25% fewer Kingsbury residents engaged in this activity than the State average. This trend continued across those skills necessary for semi-independent (figure 2.83) and independent (figure 2.89) community life.

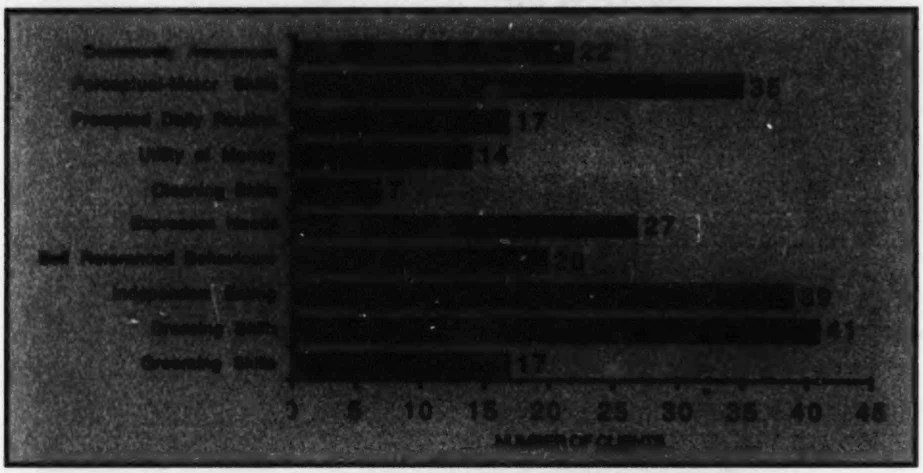

Figure 2.82: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF KINGSBURY RESIDENTS

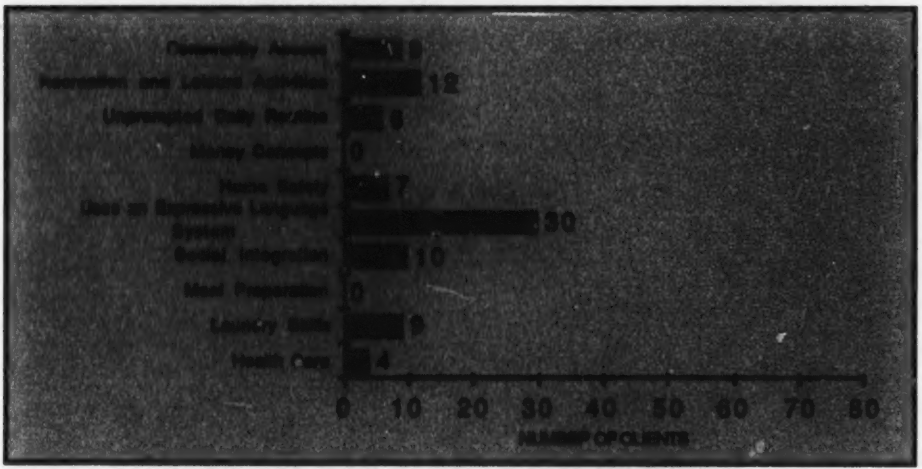

Figure 2.83: LEVEL2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF KINGSBURY RESIDENTS

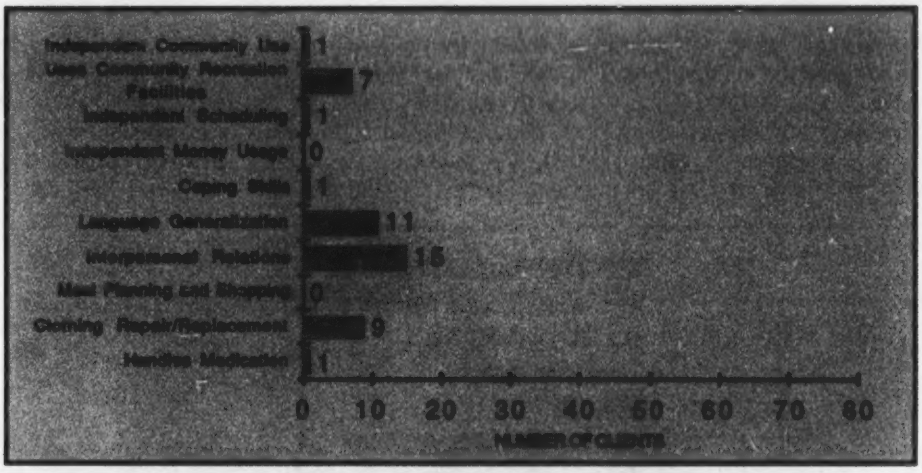

Figure 2.84: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF KINGSBURY RESIDENTS

2.3.8 Profile of Resident Population of Sunbury Training Centre

■ Number and Gender

At the time of our data collection (June-September 1986) there were 581 people, 314 men and 267 women, living at Sunbury Training Centre in Sunbury. It was reported that 400 of these people had also lived in at least one other residential institution at some stage in their lives.

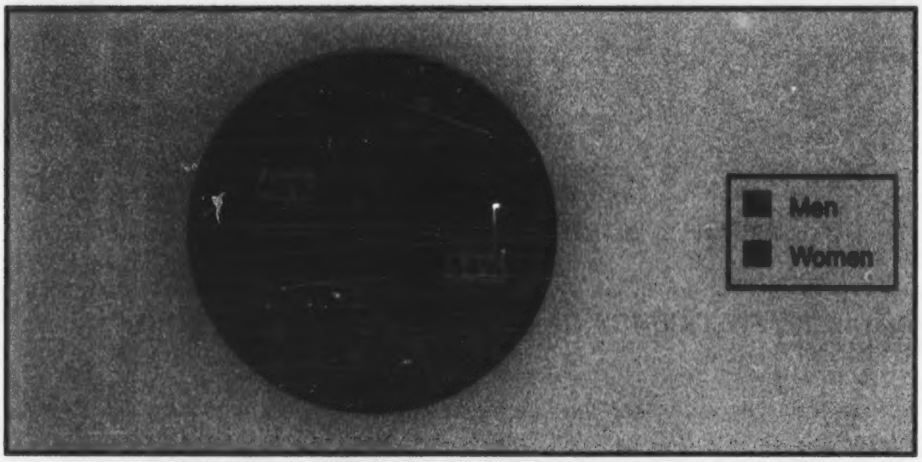

Figure 2.85: GENDER OF PEOPLE WITH INTELLECTUAL DISABILITIES RESIDING IN SUNBURY TRAINING CENTRE

■ Age Range

As shown in figure 2.84, 52% were aged between 26 and 50 years, 43% were over 51 years and 5% were aged 17 to 25 years. This data is corrected to August 1988.

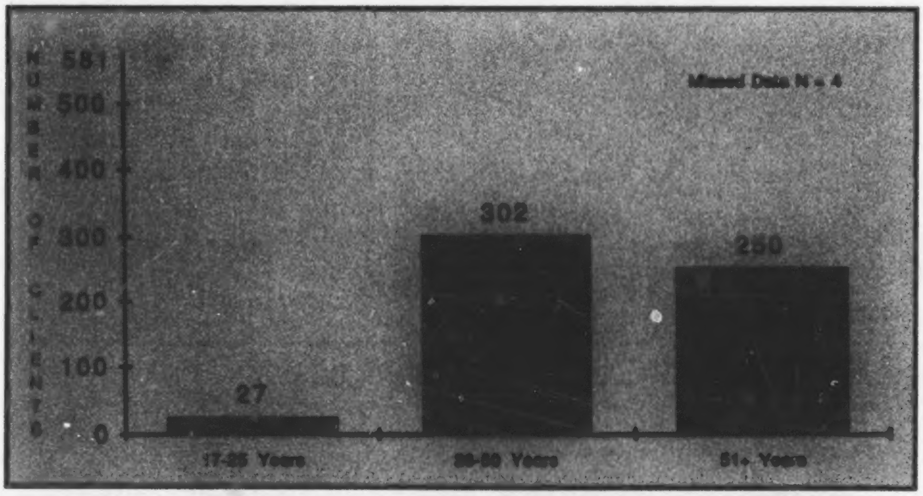

Figure 2.86: AGE RANGE OF SUNBURY RESIDENTS CORRECTED TO AUGUST 1988

- **Family Contact**

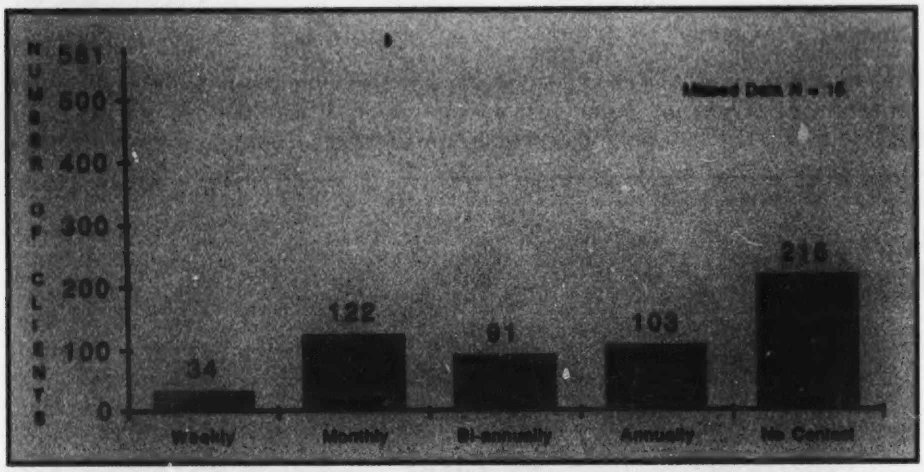

Figure 2.87: FREQUENCY OF FAMILY CONTACT WITH SUNBURY RESIDENTS

Our data indicates that 6% of Sunbury residents were in weekly contact with their families, 21% had monthly contact, 16% had contact twice each year, 18% had annual contact and 37% had no contact with family members (figure 2.87).

The type of contact residents had with their family members is shown in figure 2.88. This indicates that the most common form was visits from family, which may or may not have included an outing.

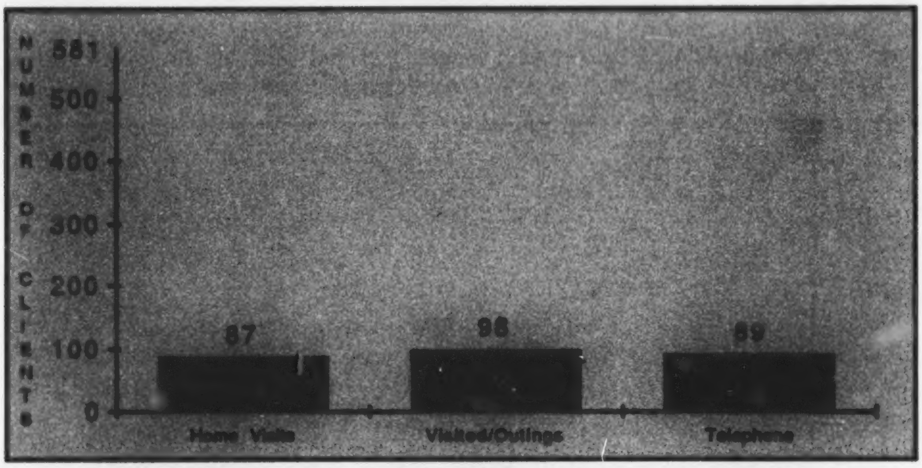

Figure 2.88: TYPE OF CONTACT SUNBURY RESIDENTS HAVE WITH THEIR FAMILIES

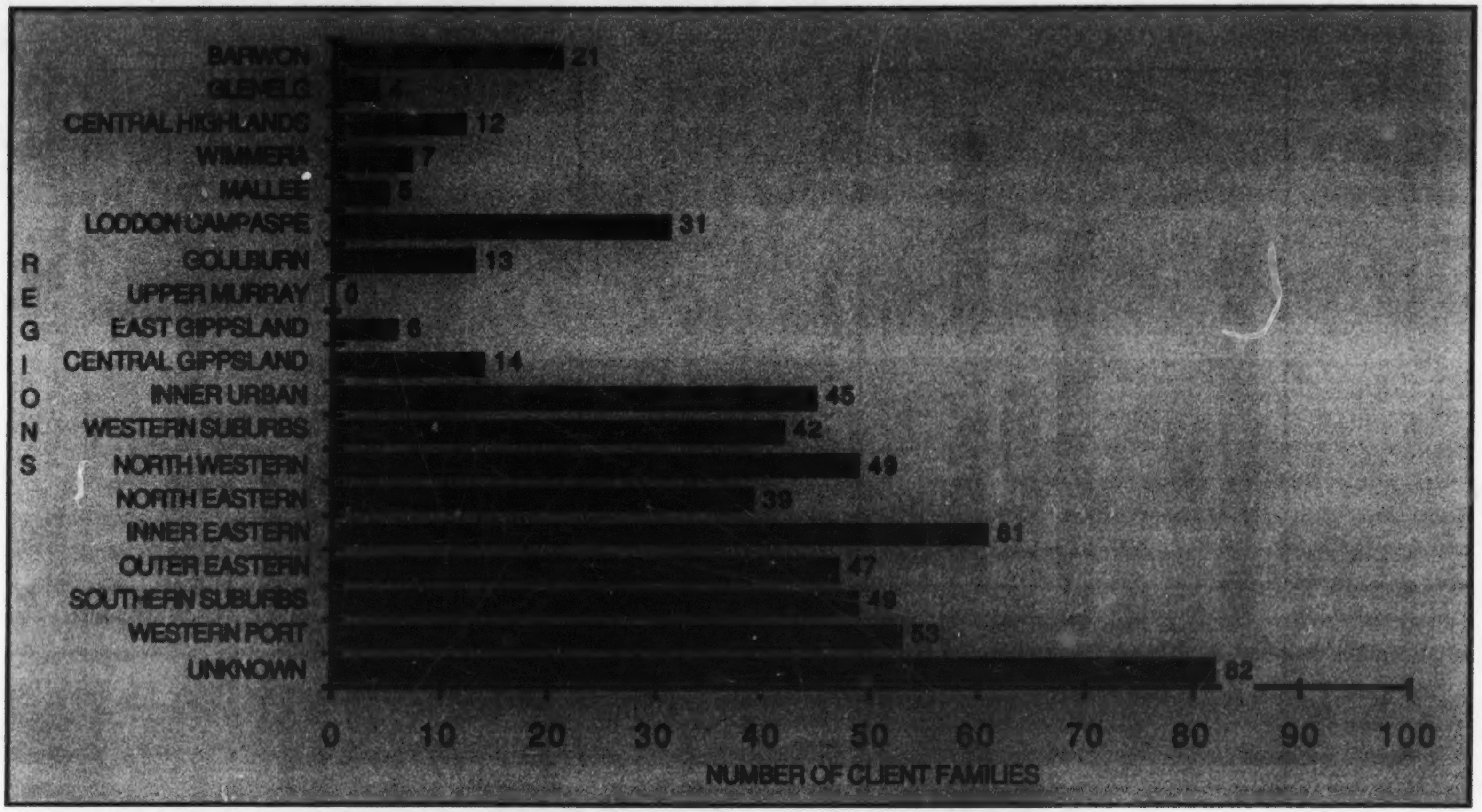

Figure 2.89: LOCATION OF FAMILIES OF SUNBURY TRAINING CENTRE RESIDENTS

▪ Location of Families

Figure 2.87 shows that the families of Sunbury residents were distributed across all regions with the exception of the Upper Murray Region. The greatest number were located in the Inner Eastern Suburbs (10%) and the whereabouts of family members of 14% of residents was not known.

▪ Secondary Disabilities

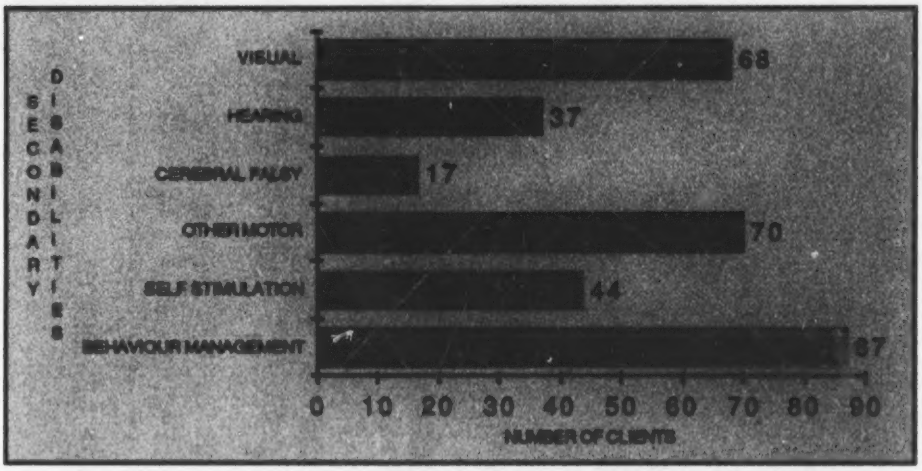

Figure 2.90: SECONDARY DISABILITIES EXPERIENCE BY SUNBURY RESIDENTS

The extent of secondary disabilities experienced by people living in Sunbury Training Centre is shown in figure 2.90. This indicates that 12% had motor disabilities other than cerebral palsy (3%), 12% had a significant visual disability and 6% a diagnosed hearing disability. 15% of residents displayed social behaviours in the institutional setting which required a behaviour management programme. Data presented in figure 2.91 indicates that there was little relationship between secondary disabilities and socially unacceptable behaviour.

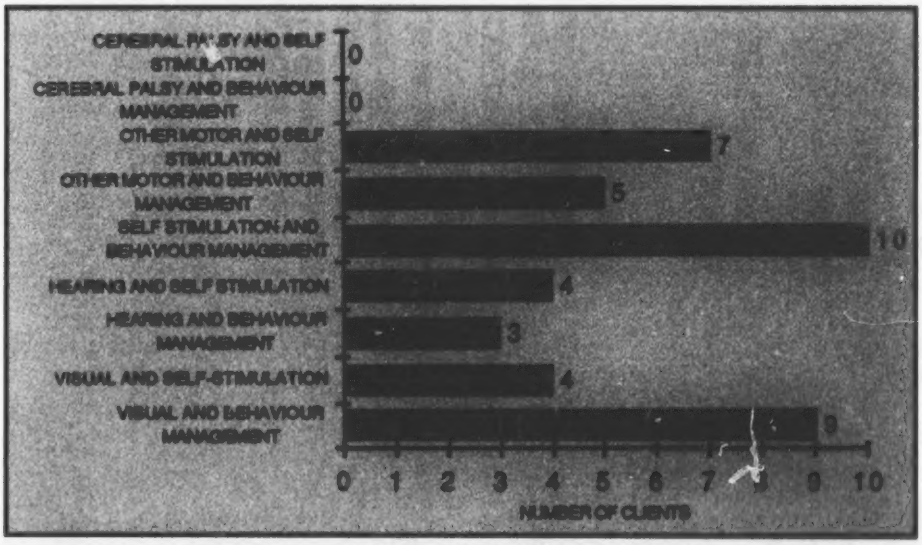

Figure 2.91: NUMBER OF SUNBURY RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO SECONDARY DISABILITIES

▪ Multiple Disabilities

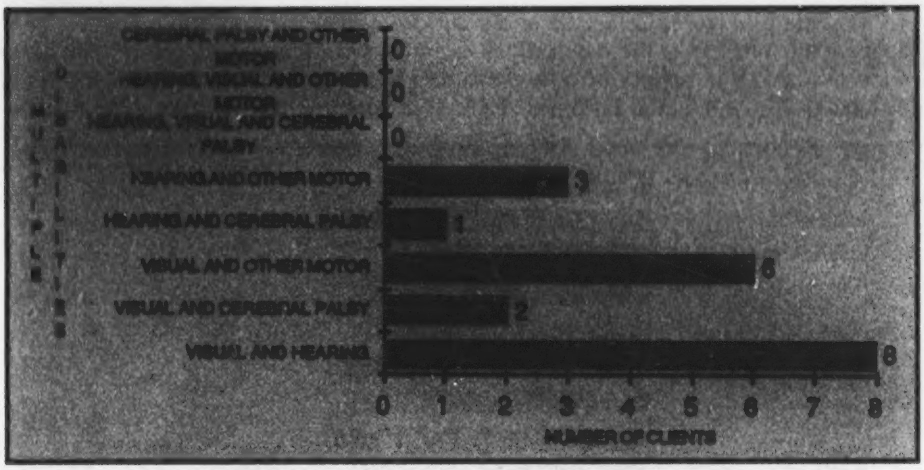

Figure 2.92: MULTIPLE DISABILITIES EXPERIENCED BY SUNBURY RESIDENTS

Out data (figure 2.92) indicates that very few people living in Sunbury had multiple disabilities.

▪ Medical Conditions

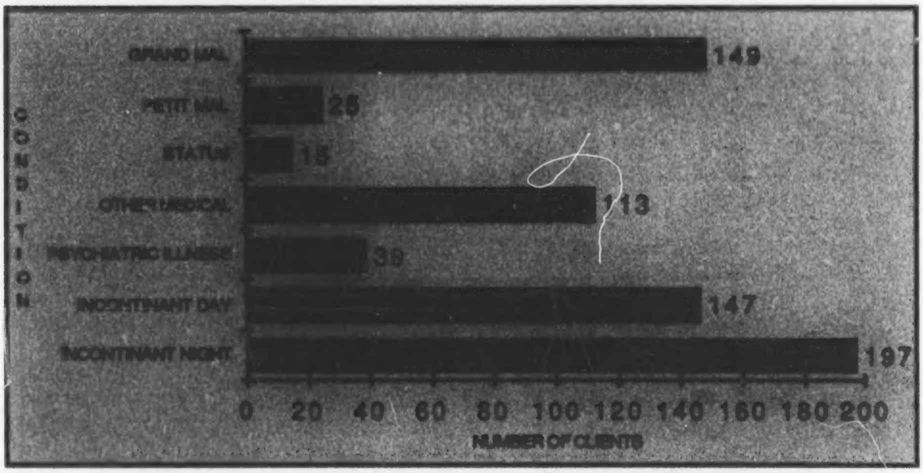

Figure 2.93: MEDICAL CONDITIONS OF SUNBURY RESIDENTS

As indicated in figure 2.93, the most common medical disorder was incontinence at night (34% of residents) and during the day (25%). 26% of residents had grand mal epilepsy and 7% had a diagnosed psychiatric illness.

▪ Skill Strength's in Activities of Ordinary Daily Life

Data presented in figures 2.94, 2.95 and 2.96 shows the total number of Sunbury residents who independently performed the critical skills required for ordinary daily community life at the three levels measured by our checklist. When this data is compared with the Statewide Training Centre data (figures 2.10, 2.11 and 2.12) it is revealed that Sunbury data is close to the Statewide figures.

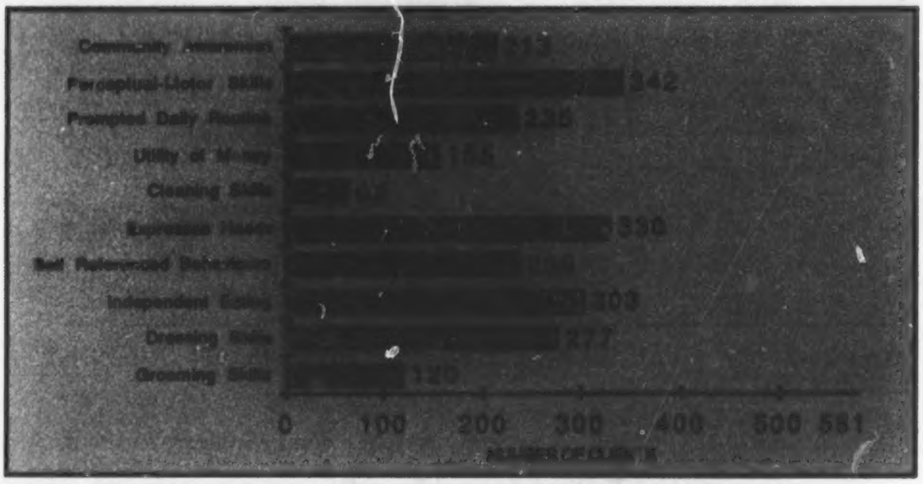

Figure 2.94: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF SUNBURY RESIDENTS

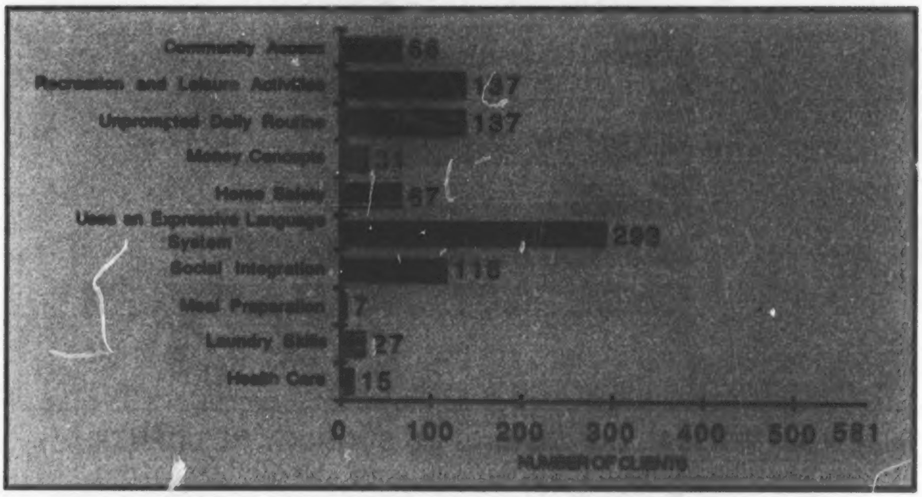

Figure 2.95: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF SUNBURY RESIDENTS

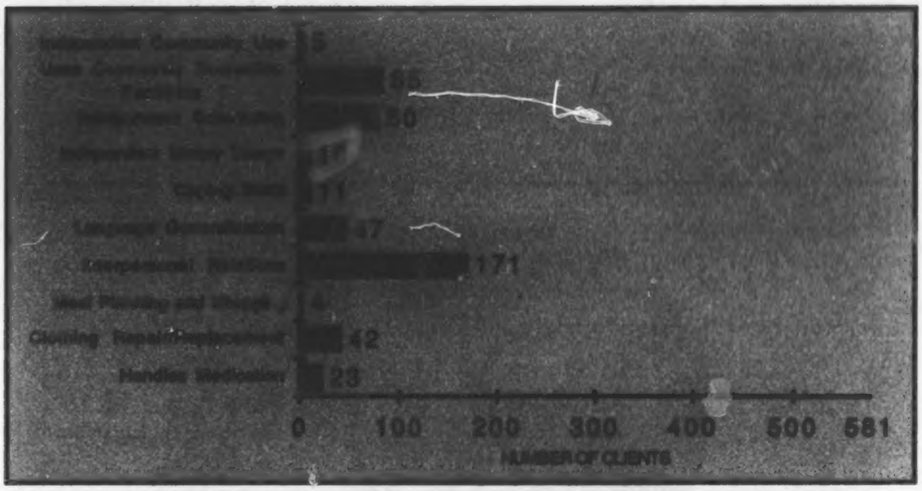

Figure 2.96: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF SUNBURY RESIDENTS

2.3.9 Profile of Resident Population of Sandhurst Training Centre

▪ Number and Gender

Forty-five men lived at Sandhurst Training Centre at the time of our data collection, of whom 27 or 60% had also lived in at least one other residential institution.

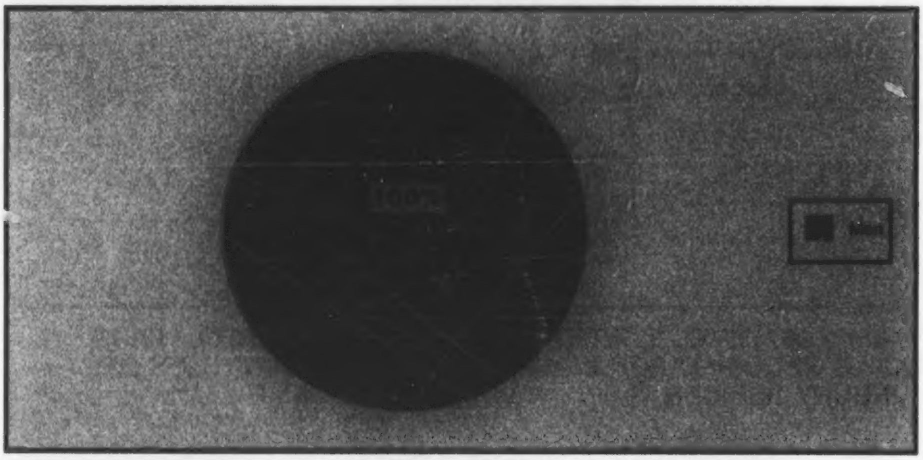

Figure 2.97: GENDER OF PEOPLE LIVING AT SANDHURST TRAINING CENTRE

▪ Age Range

As shown in figure 2.98, 93% of Sandhurst residents were aged between 26 and 50 years, corrected to August 1988.

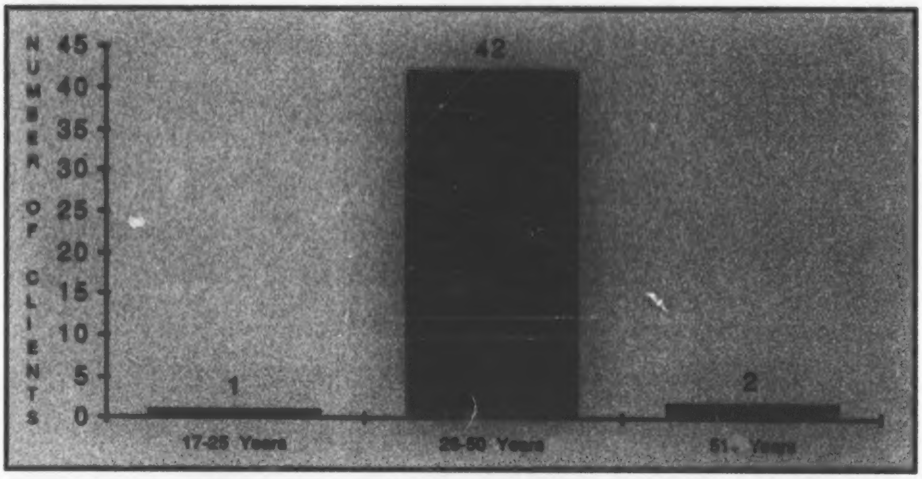

Figure 2.98: AGE RANGE OF SANDHURST RESIDENTS CORRECTED TO AUGUST 1988

▪ Family Contact

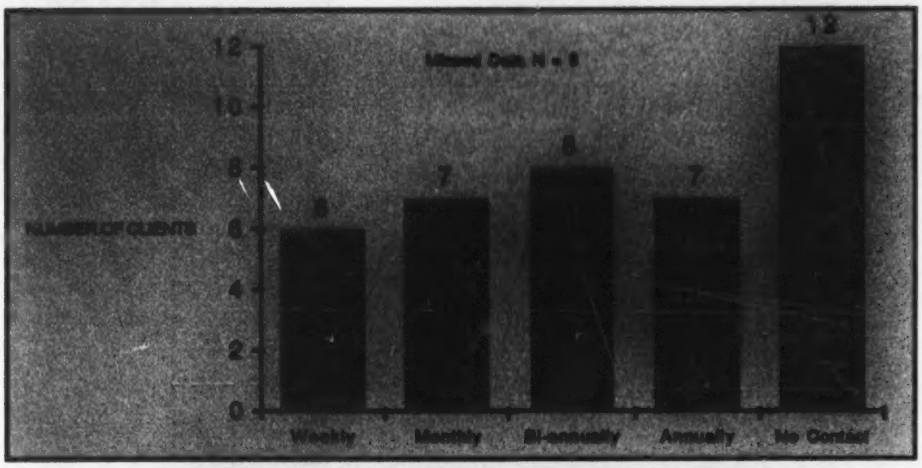

Figure 2.99: FREQUENCY OF CONTACT WITH FAMILIES BY SANDHURST RESIDENTS

18% of the men living at Sandhurst had contact with their families twice each year, 13% had weekly contact, 13% had monthly contact, and 15% had annual contact. It was reported that 27% had no contact with family members. (Figure 2.99)

As can be seen in figure 2.100, the most usual form of contact was visits to the family home.

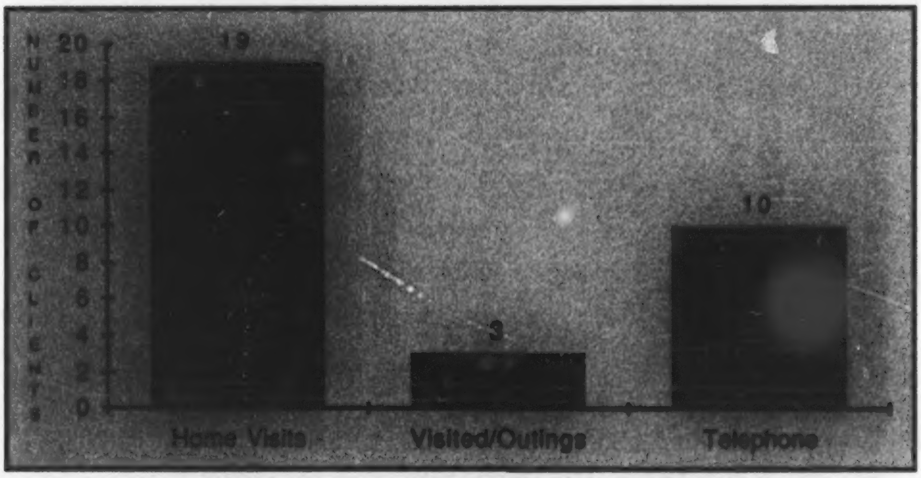

Figure 2.100: TYPE OF CONTACT SANDHURST RESIDENTS HAD WITH THEIR FAMILIES

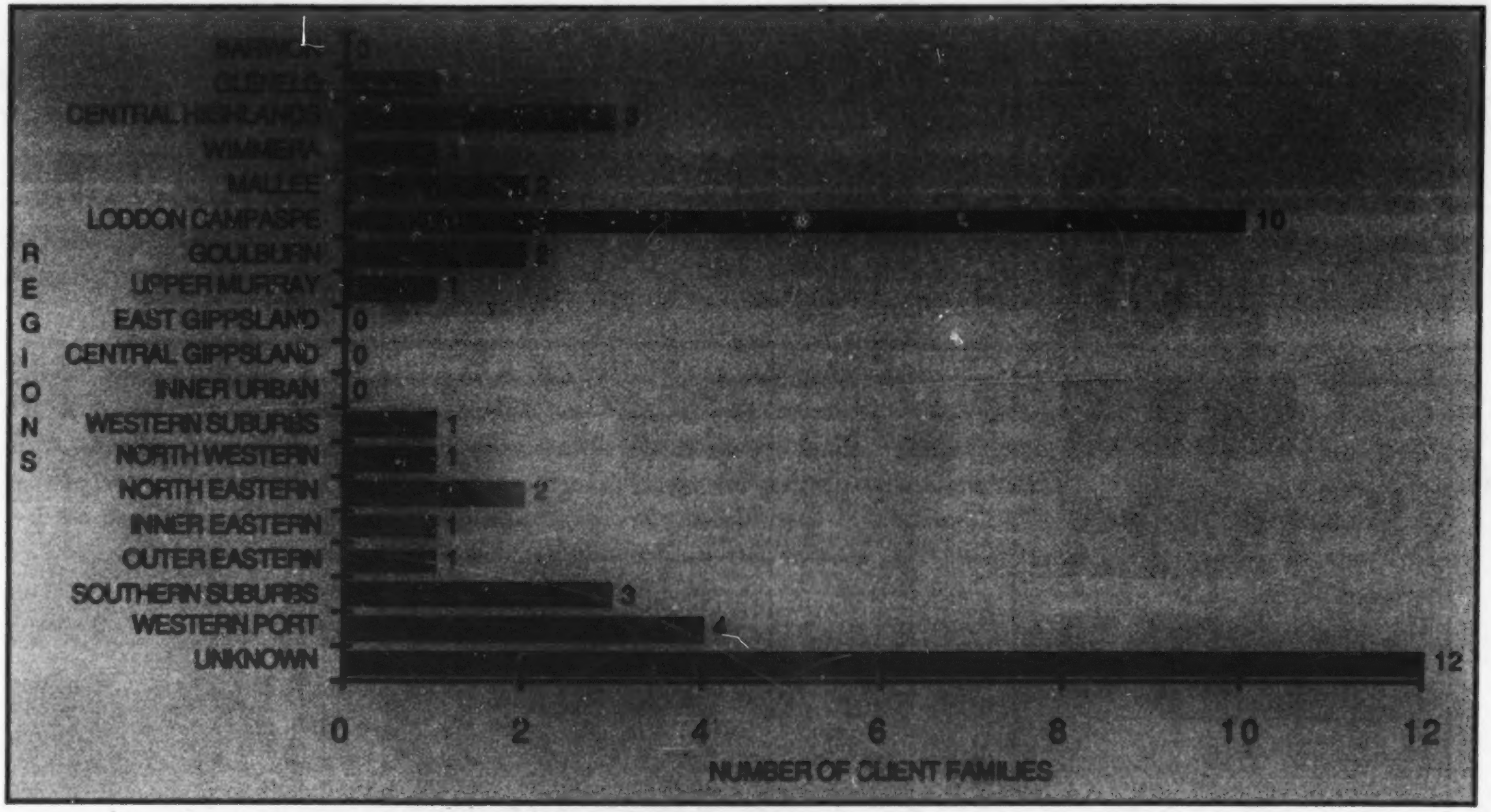

Figure 2.101: LOCATION OF FAMILIES OF SANDHURST RESIDENTS

▪ Location of Families

Data presented in figure 2.101 indicates that, although the families of Sandhurst people were scattered across much of the State, most (22%) were located in the Loddon/Campaspe Region, were Sandhurst is situated. The whereabouts of the families of 27% of residents was not known.

▪ Secondary Disabilities

Data presented in Figure 2.102 and 2.103 shows that very few Sandhurst residents experienced secondary disabilities, although 20% did exhibit social behaviours in the institutional setting which required behavioural intervention.

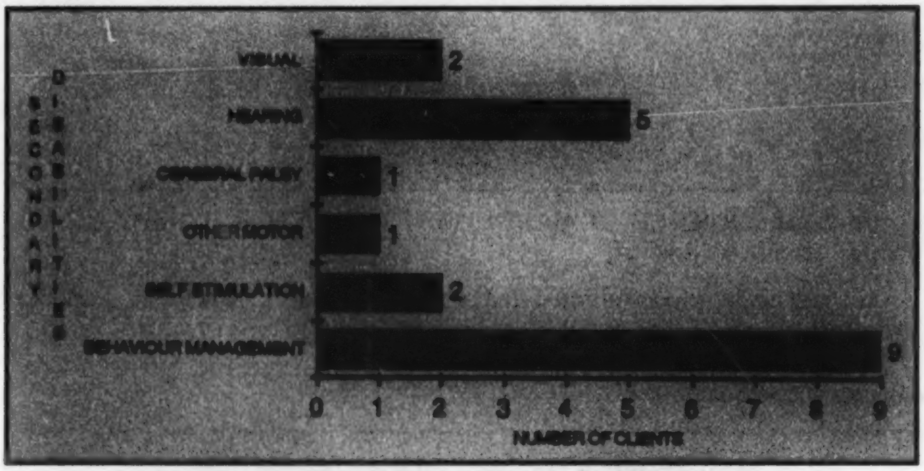

Figure 2.102: SECONDARY DISABILITIES EXPERIENCED BY SANDHURST RESIDENTS

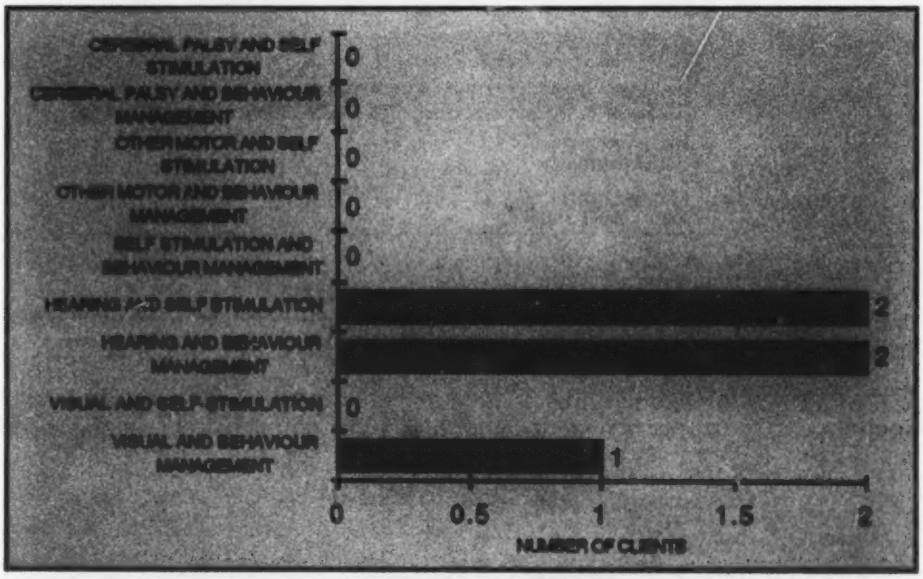

Figure 2.103: NUMBER OF SANDHURST RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO THEIR SECONDARY DISABILITIES

- **Multiple Disabilities**

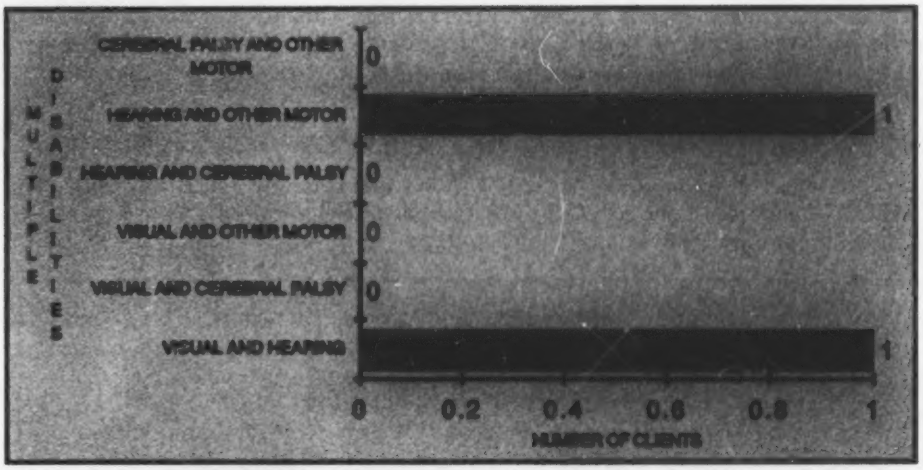

Figure 2.104: NUMBER OF SANDHURST RESIDENTS EXPERIENCING MULTIPLE DISABILITIES

As indicated above, it was reported that only two people at Sandhurst experienced multiple disabilities.

- **Medical Conditions**

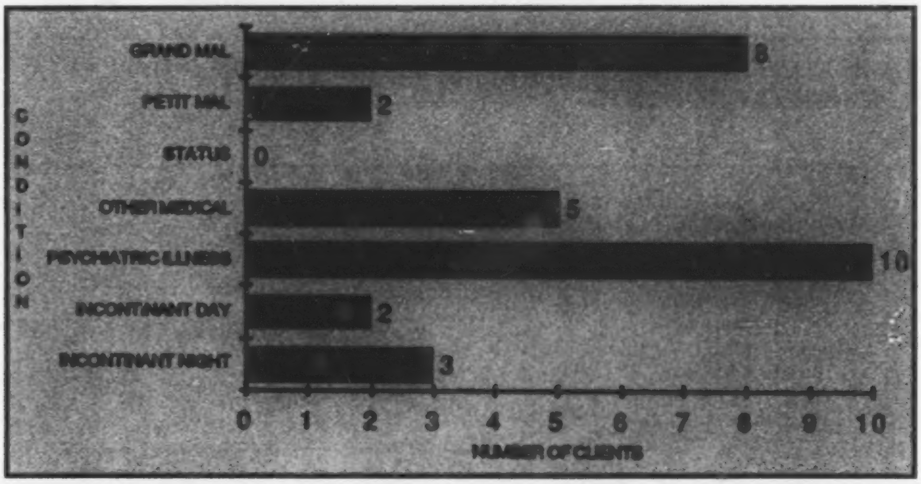

Figure 2.105: MEDICAL CONDITIONS OF SANDHURST RESIDENTS

Data presented in figure 2.105, indicates that the most common medical condition experienced by people living at Sandhurst were a psychiatric illness (22%). This is considerably higher than the State Training Centre population figure of 8%.

▪ Skill Strengths in Activities of Ordinary Daily Life

Figures 2.106, 2.107 and 2.108 present data relating to the total number of Sandhurst residents who were independent in the critical skills required for an ordinary daily life in a community setting. When these are compared with the Statewide Training Centre profile figures in figures 2.10, 2.11 and 2.12, it is shown that more Sandhurst people performed these skills independently as part of their daily lives than the State average.

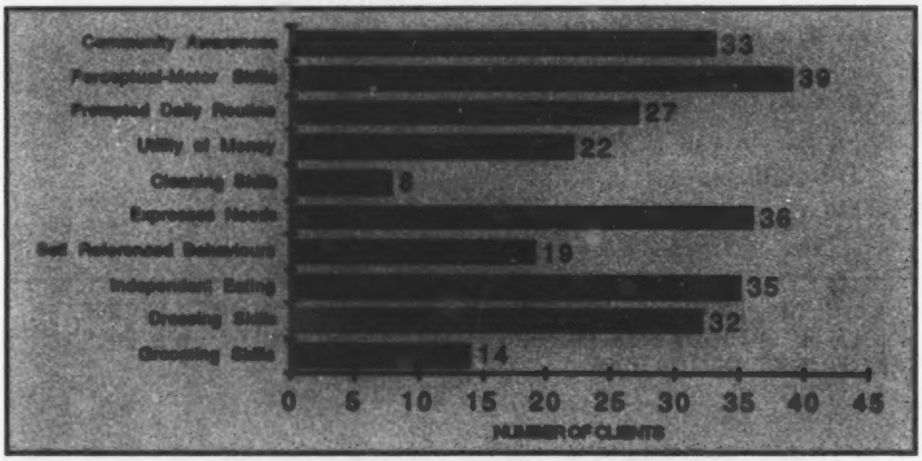

Figure 2.106: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF SANDHURST RESIDENTS

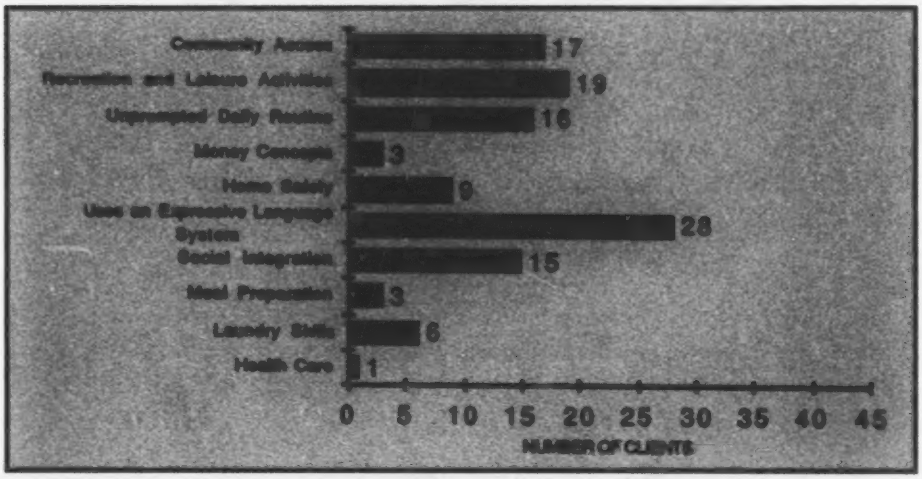

Figure 2.107: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF SANDHURST RESIDENTS

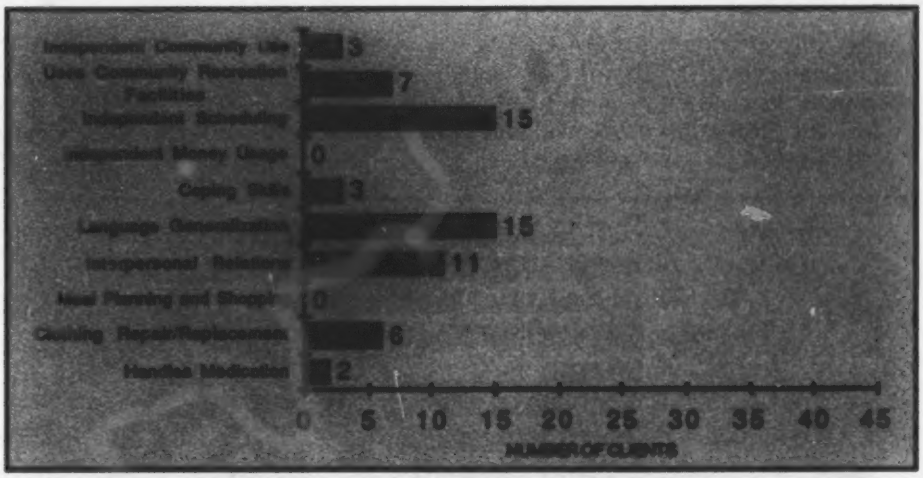

Figure 2.108: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF SANDHURST RESIDENTS

2.3.10 Profile of Resident Population of Pleasant Creek Training Centre

▪ Number and Gender

127 people, of whom 77 were male and 50 were female, lived at Pleasant Creek Training Centre in Stawell at the time data was collected. 83 or 63% had also lived in at least one other residential institution before moving to Pleasant Creek.

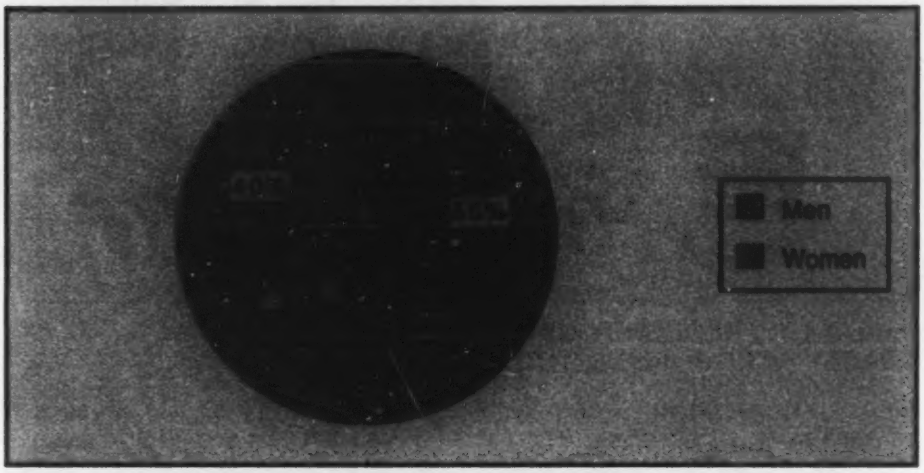

Figure 2.109: GENDER OF PEOPLE LIVING AT PLEASANT CREEK TRAINING CENTRE

▪ Age Range

As shown below, 67% of Pleasant Creek residents were aged between 17 to 25 years, 23% were aged 26 to 50 years and 10% were children. These figures are corrected to August 1988.

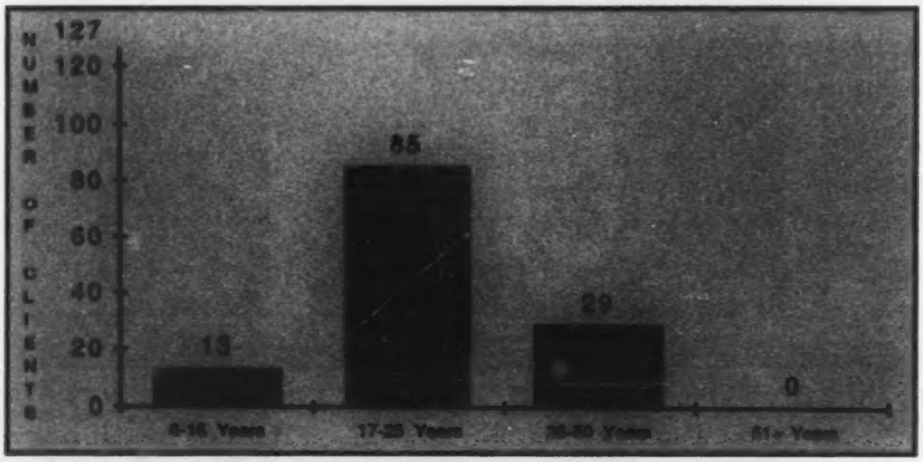

Figure 2.110: AGE RANGE OF PLEASANT CREEK RESIDENTS, CORRECTED TO AUGUST 1988

▪ Family Contact

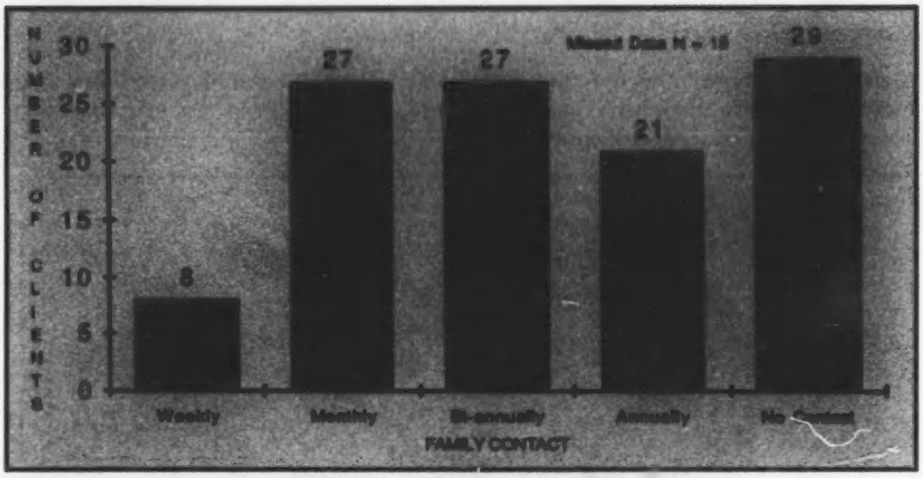

Figure 2.111: FREQUENCY OF FAMILY CONTACT WITH PLEASANT CREEK RESIDENTS

Our data indicates that 6% of residents had contact with their families each week, 21% had monthly contact, 21% were contacted twice each year and 17% had annual contact. 23% of Pleasant Creek residents had no contact with family members. (Figure 2.111)

As can be seen in figure 2.112, the most usual form of contact was visits to the family home (44% of residents).

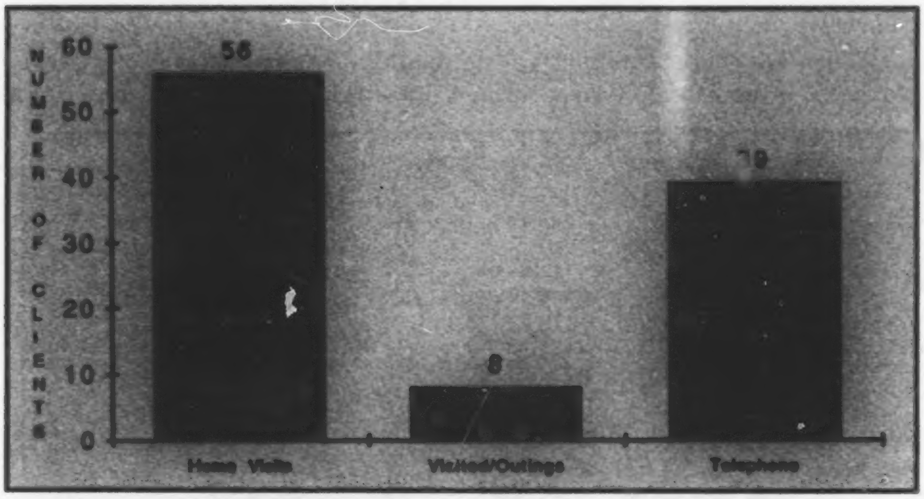

Figure 2.112: TYPE OF CONTACT PLEASANT CREEK RESIDENTS HAVE WITH THEIR FAMILIES

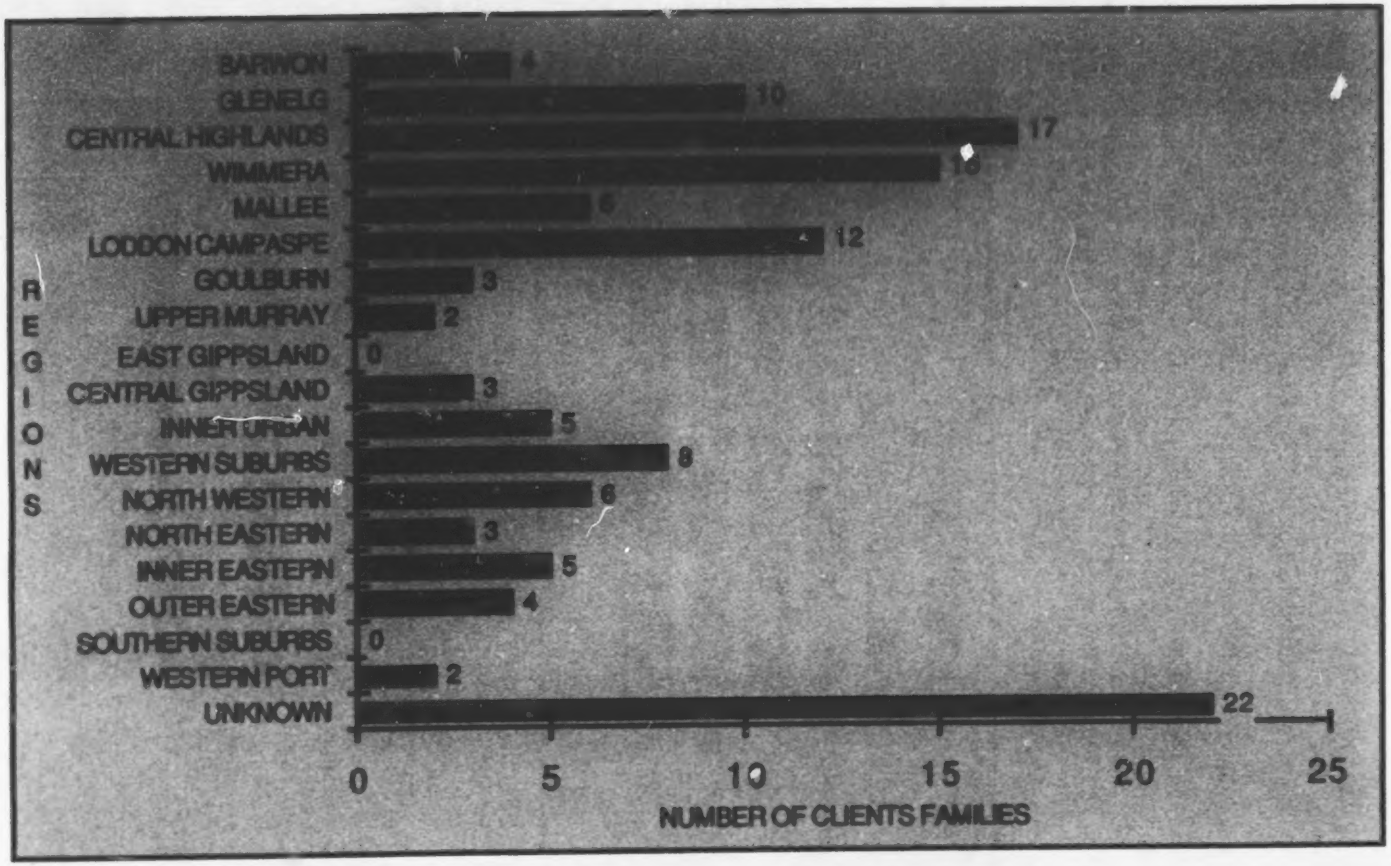

Figure 2.113: LOCATION OF FAMILIES OF PLEASANT CREEK RESIDENTS

▪ Location of Families

As can be seen in figure 2.113, 13% of families lived in the Central Highlands Region where Pleasant Creek is situated, 12% lived in the neighbouring Wimmera Region and 9% lived in the Lodden/Campaspe Region. The whereabouts of 17% of families was not known.

▪ Secondary Disabilities

The data presented in figures 2.114 and 2.115 indicate that the most common secondary disability experienced by the people living at Pleasant Creek was a motor disability (21%) other than cerebral palsy (11%). 19% exhibited social behaviours in the institutional setting which required behavioural intervention and 17% regularly engaged in repetitive self stimulatory/self abusive behaviours. The data indicates that there was little relationship between secondary disability and undesirable social behaviour patterns (figure 2.115).

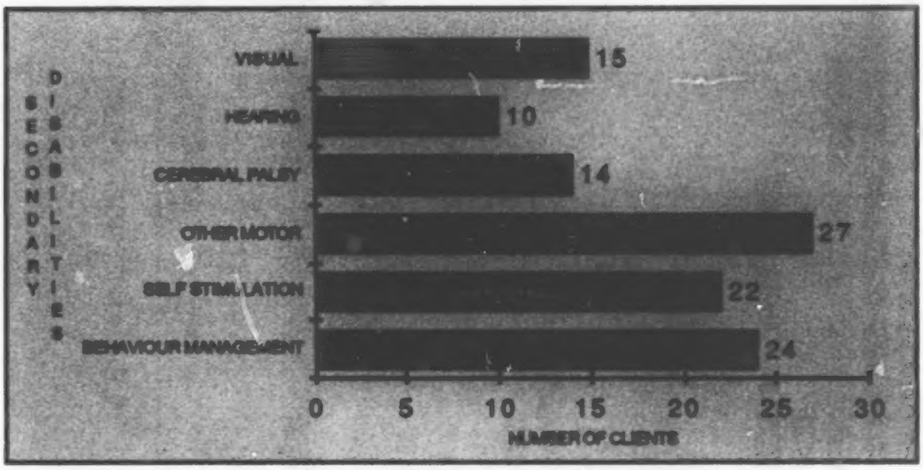

Figure 2.114: SECONDARY DISABILITIES EXPERIENCED BY PLEASANT CREEK RESIDENTS

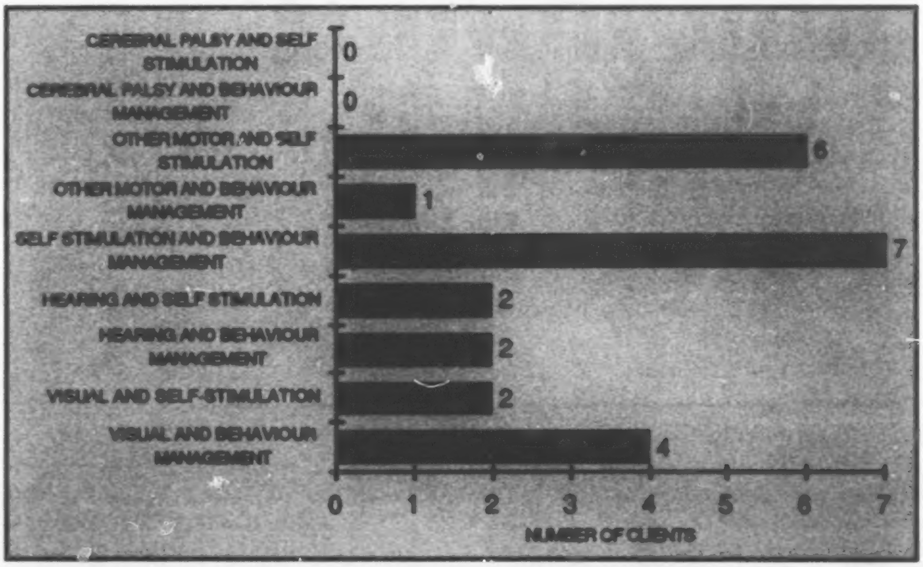

Figure 2.115: NUMBER OF PLEASANT CREEK RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO THEIR SECONDARY DISABILITIES

■ Multiple Disabilities

The data below shows that few people living at Pleasant Creek experienced multiple disabilities.

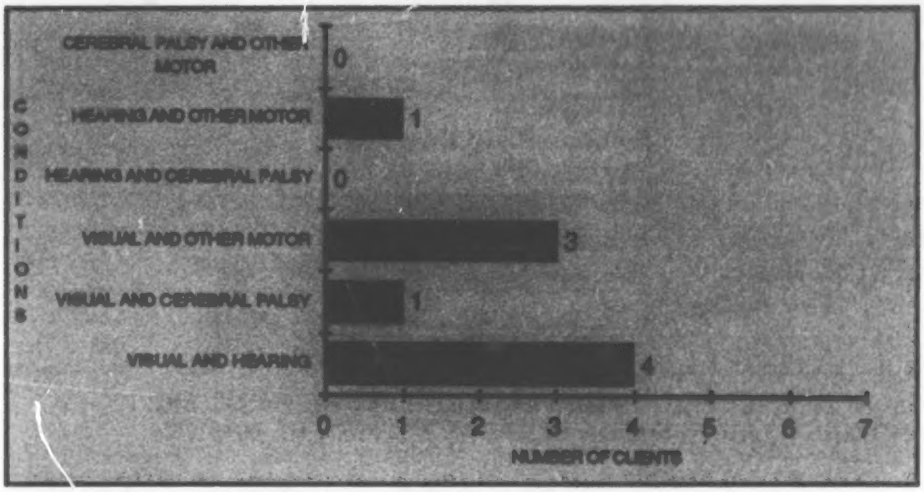

Figure 2.116: NUMBER OF PLEASANT CREEK RESIDENTS WITH MULTIPLE DISABILITIES

■ Medical Conditions

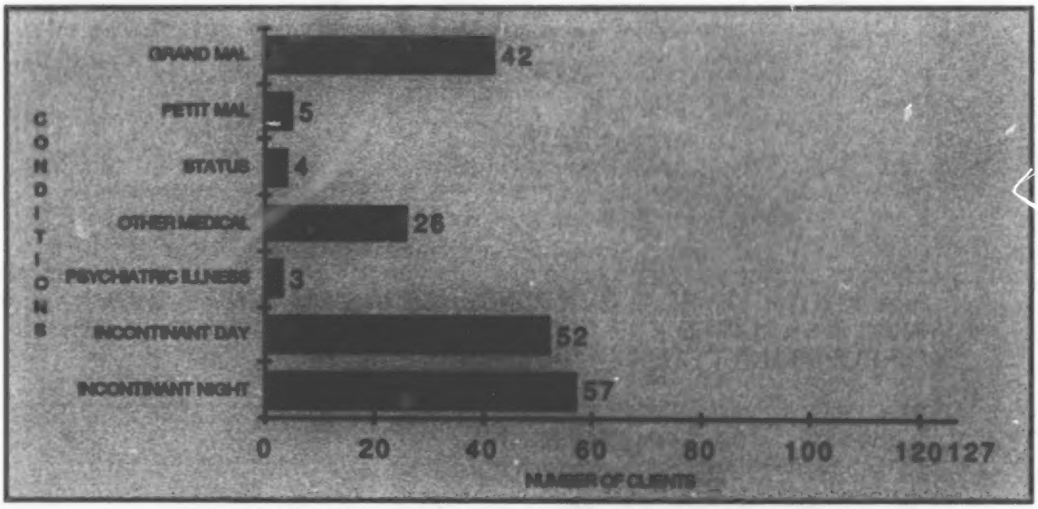

Figure 2.117: MEDICAL CONDITIONS OF PLEASANT CREEK RESIDENTS

As shown above, the most common medical problem of this population was incontinence at night (45%) and during the day (41%).

■ Skill Strengths in Activities of Ordinary Daily Life

Data summarized in figures 2.118, 2.119 and 2.120 displays the total number of Pleasant Creek residents who independently performed the critical skills required for ordinary daily community life at the three levels measured by our checklist. When this data is compared with the Statewide Training Centre data (figures 2.10, 2.11 and 2.12) it is shown that a much larger number of Pleasant Creek residents performed at a much higher level on most skills than the Statewide level across all three skill areas.

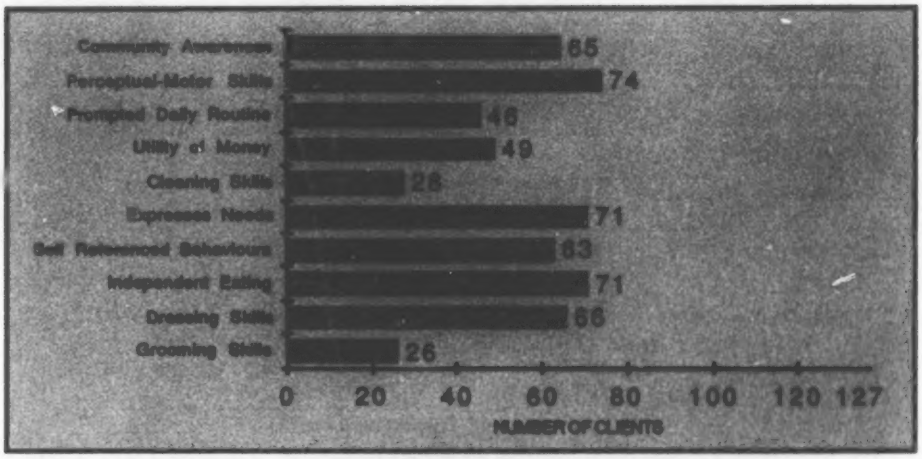

Figure 2.118: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF PLEASANT CREEK RESIDENTS

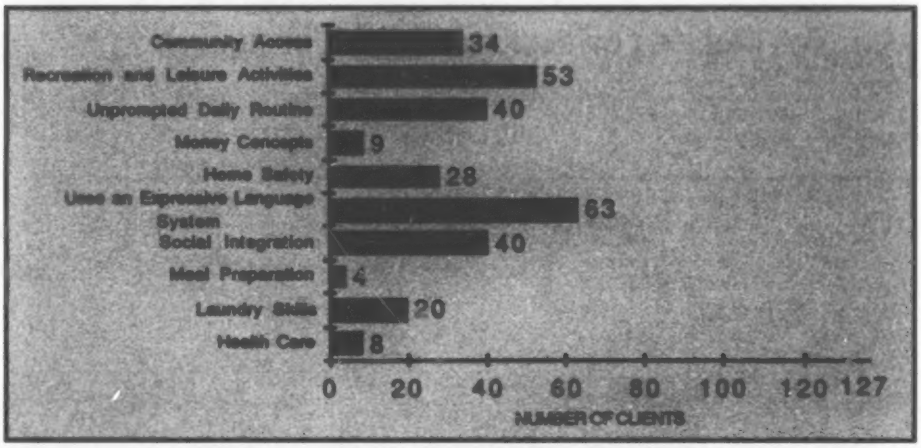

Figure 2.119: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF PLEASANT CREEK RESIDENTS

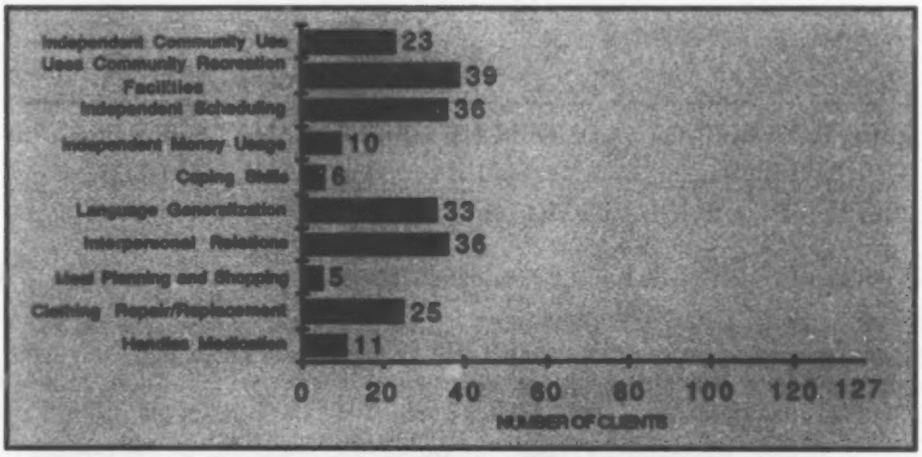

Figure 2.120: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF PLEASANT CREEK RESIDENTS

2.3.11 Profile of Resident Population of Colanda Training Centre

- **Number and Gender**

At the time of our data collection (June-September 1986) there were 166 people living at Colanda Training Centre in Colac. 96 were men and 70 were women. It was reported that 137 (82%) had also lived in at least one other residential institution prior to taking up residence at Colanda.

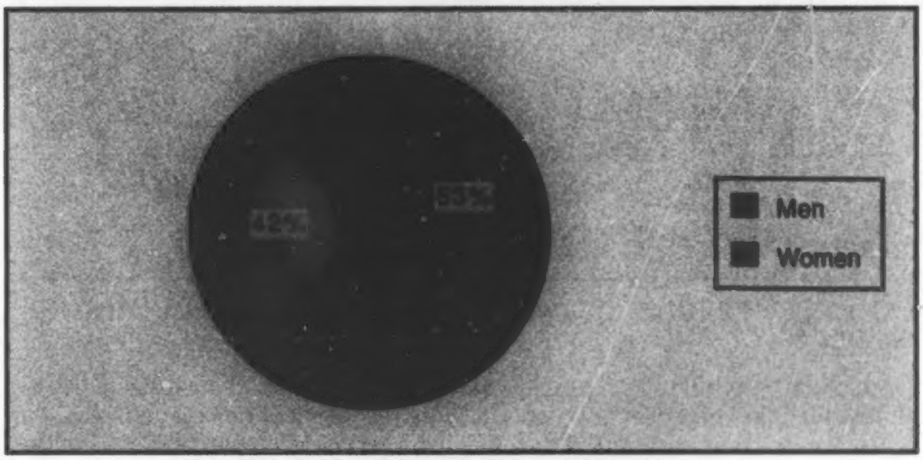

Figure 2.121: GENDER OF COLANDA RESIDENTS

- **Age Range**

As shown below, 49% of Colanda residents were in the 26 to 50 years age bracket, 51% were young adults, 8% were over 51 years and 12% were children. This data has been corrected to August 1988.

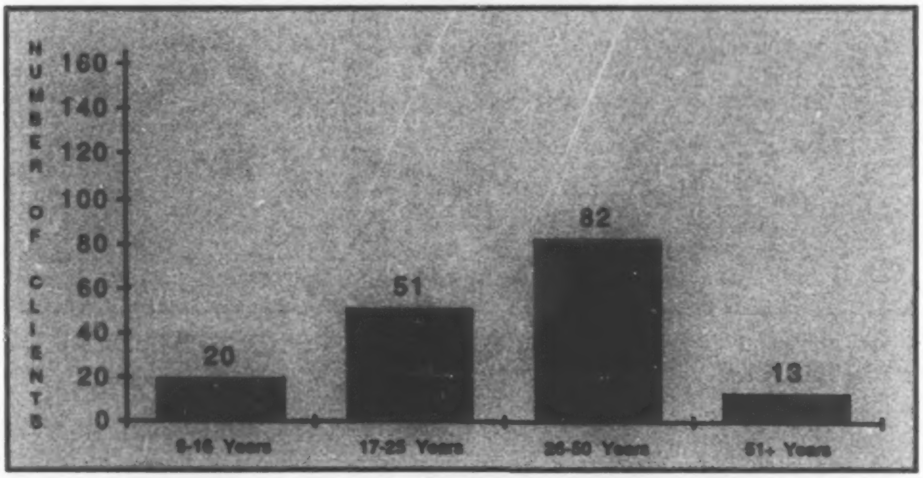

Figure 2.122: AGE RANGE OF COLANDA RESIDENTS CORRECTED TO AUGUST 1988

- **Family Contact**

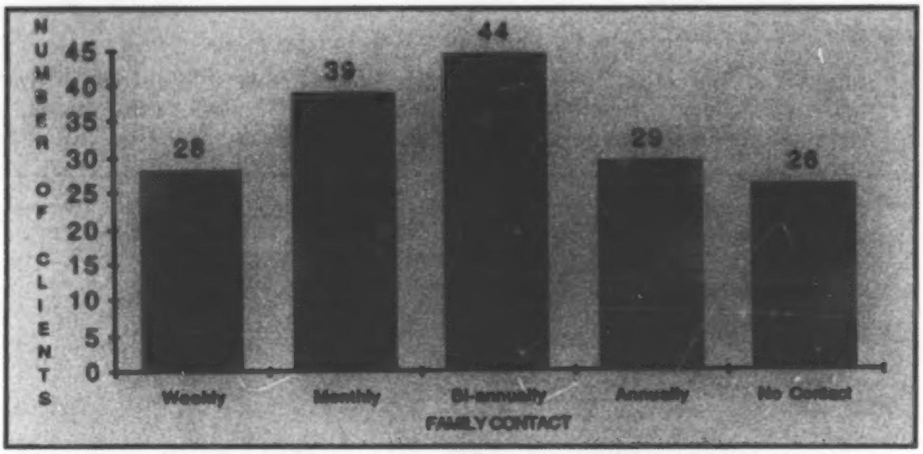

Figure 2.123: FREQUENCY OF FAMILY CONTACT WITH COLANDA RESIDENTS

Our data indicates that 17% of the people living at Colanda had contact with their families each week, 23% had monthly contact, 27% had contact twice each year, and 17% had annual contact. It was reported that 16% had no contact with families. (Figure 2.123). As shown below, telephone contact was the most common form of contact.

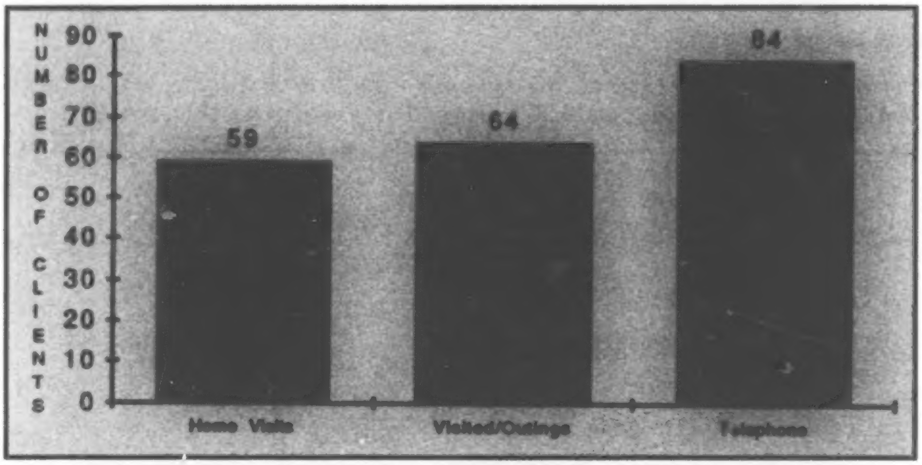

Figure 2.124: TYPE OF CONTACT COLANDA RESIDENTS HAD WITH THEIR FAMILIES

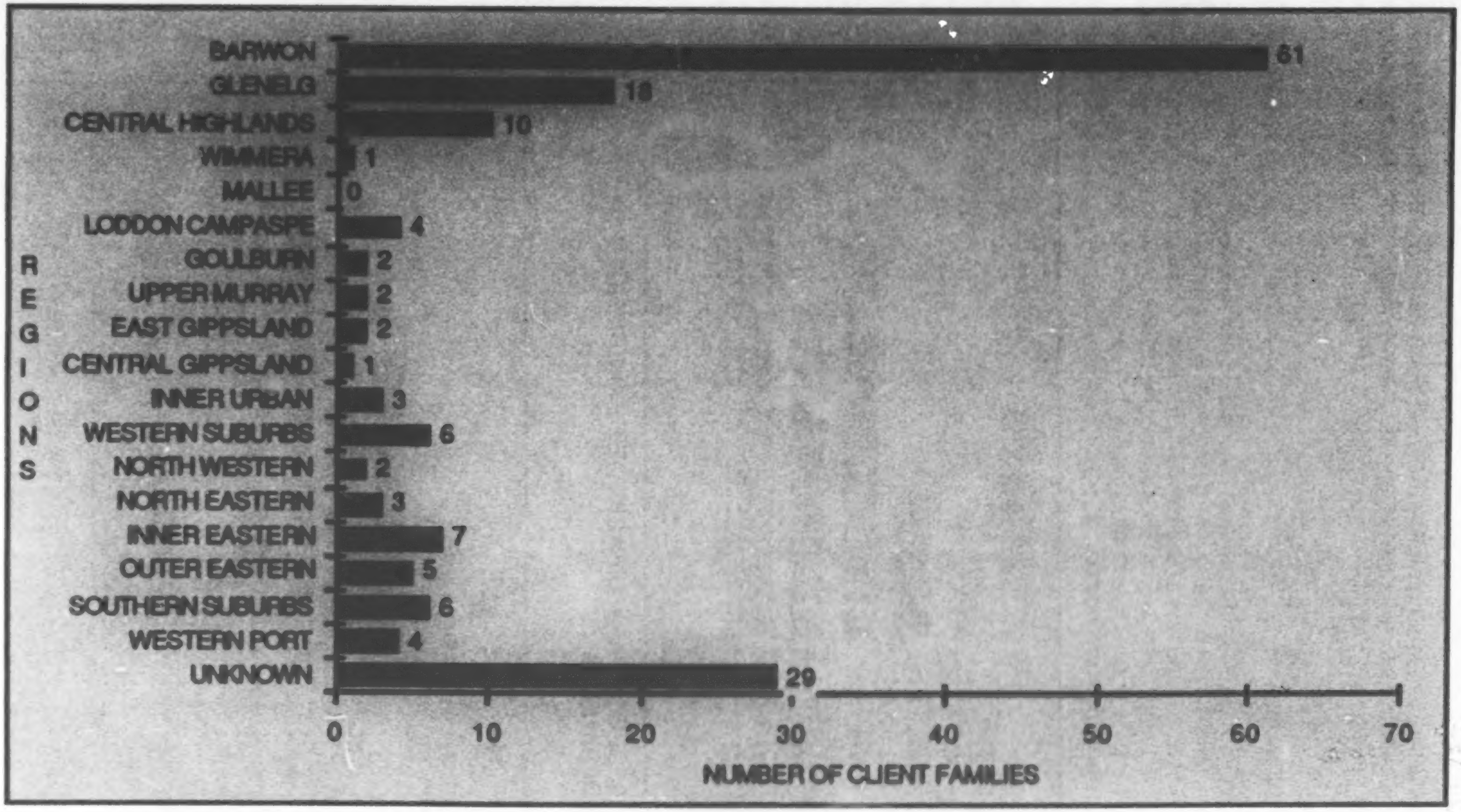

Figure 2.125: LOCATION OF FAMILIES OF COLANDA RESIDENTS

▪ Location of Families

As can be seen in figure 2.123, most families of Colanda residents lived in the Barwon Region (37%) where Colanda itself is situated or in the neighbouring Glenelg Region (11%) although families were scattered across most of the State. It was reported that the whereabouts of 17% of families was not known.

▪ Secondary Disabilities

As shown in figure 2.126, the most common secondary disability experienced by people living at Colanda was a motor disability (28%) other than cerebral palsy (10%). 31% of residents displayed social behaviours in the institutional setting which required behaviour management intervention and 21% exhibited repetitive self-stimulatory/self-abusive behaviour patterns. Data shown in figure 2.127, shows that 24% of people with motor disabilities (excluding cerebral palsy) also required a behaviour management programme.

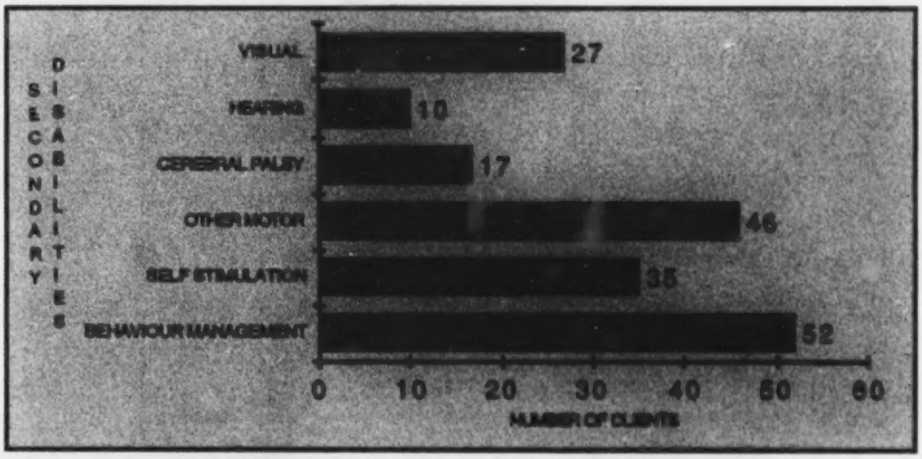

Figure 2.126: SECONDARY DISABILITIES EXPERIENCED BY COLANDA RESIDENTS

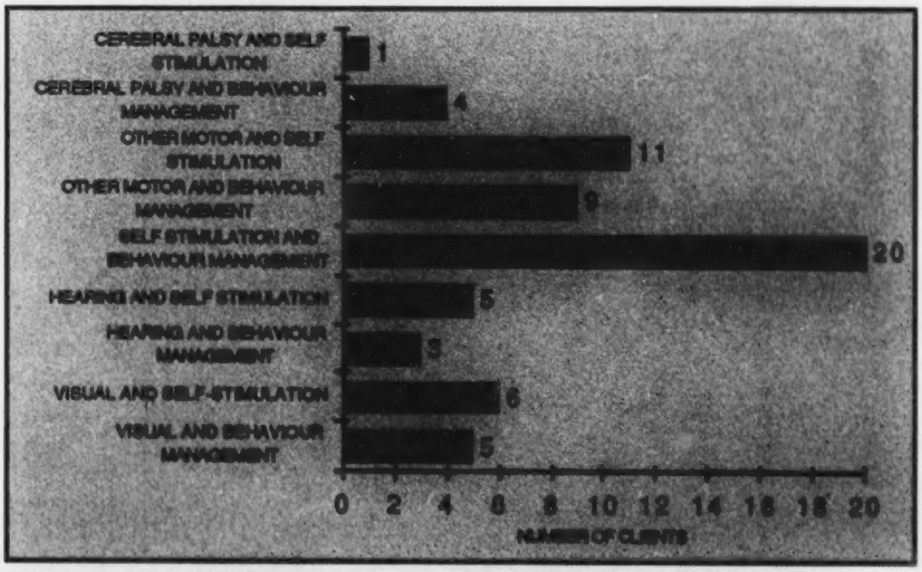

Figure 2.127: NUMBER OF COLANDA RESIDENTS EXHIBITING SOCIAL BEHAVIOUR PROBLEMS IN ADDITION TO THEIR SECONDARY DISABILITIES

- **Multiple Disabilities**

Data presented below shows that 16 people living at Colanda experienced multiple disabilities. The most usual was the combination of a motor disability and visual impairment.

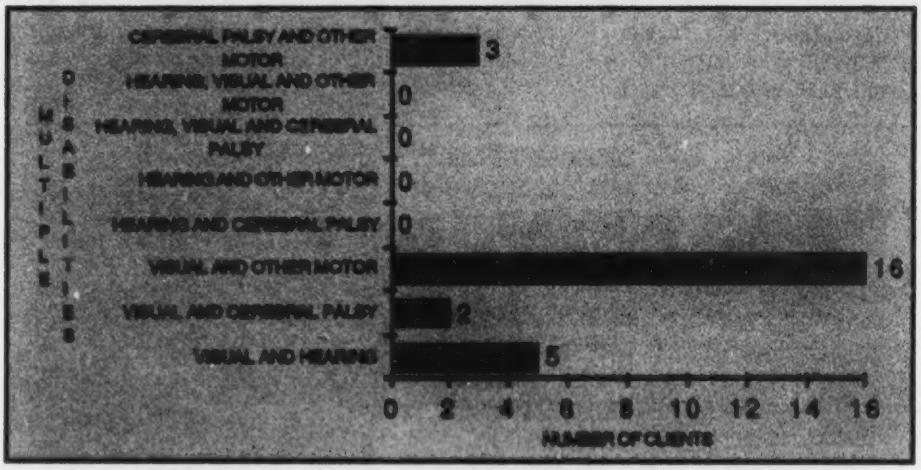

Figure 2.128: NUMBER OF COLANDA RESIDENTS WITH MULTIPLE DISABILITIES

- **Medical Conditions**

As shown in figure 2.129, the most usual medical condition was that of incontinence (49% night: 44% day)

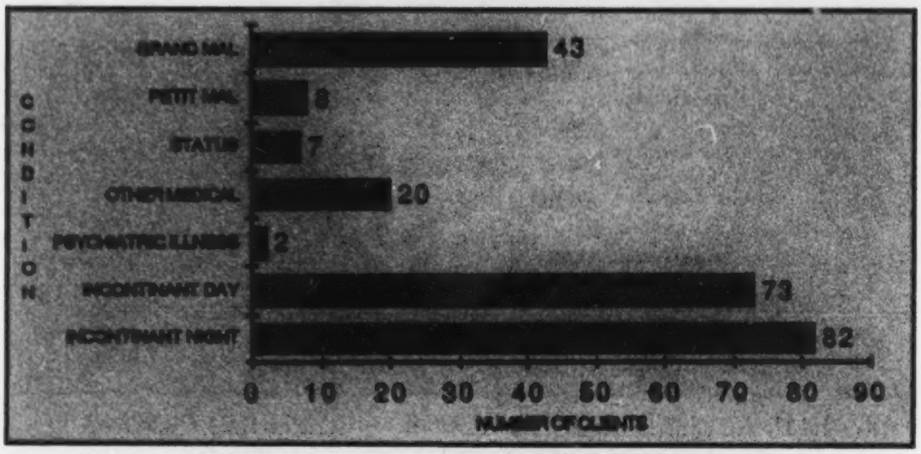

Figure 2.129: MEDICAL CONDITIONS EXPERIENCED BY COLANDA RESIDENTS

■ Skill Strengths in Activities of Ordinary Daily Life

Data presented in figures 2.130, 2.131 and 2.132 shows the total number of Colanda residents who independently performed the critical skills required for ordinary daily life in the community as measured by our checklist. When this data is compared with the Statewide Training Centre profile (figures 2.10, 2.11 and 2.12) it is evident that fewer Colanda residents perform these skills without assistance in the course of their daily lives. This trend is consistent across all three levels, but most marked in level one skills.

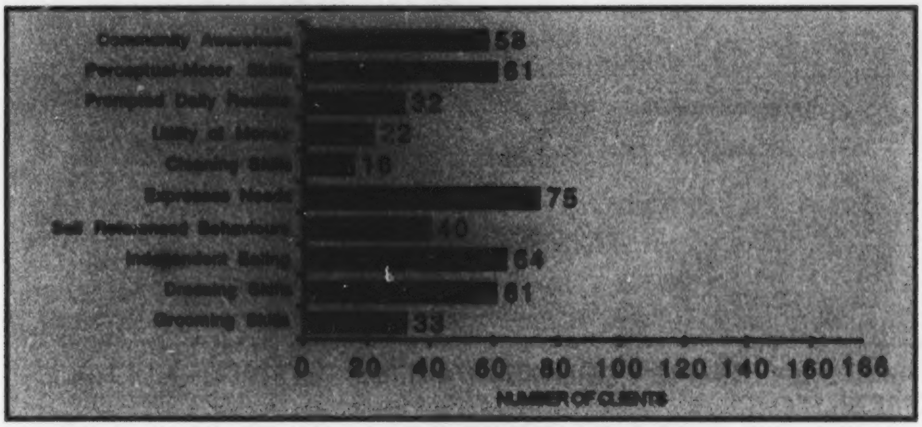

Figure 2.130: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE OF COLANDA RESIDENTS

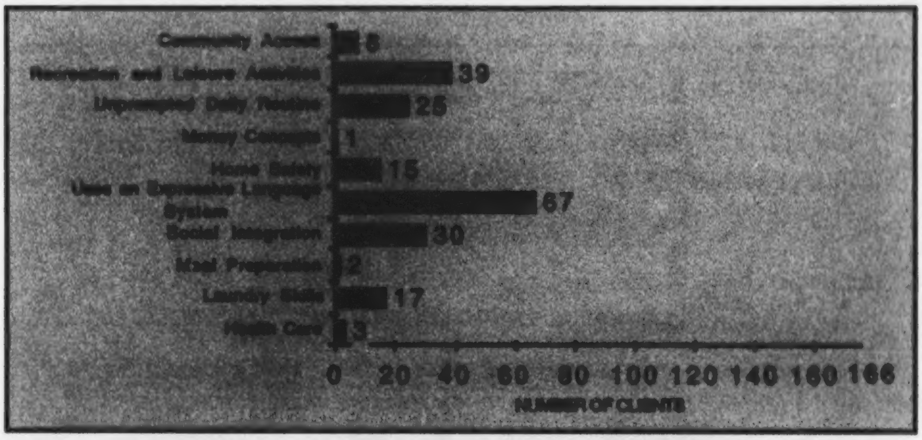

Figure 2.131: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE OF COLANDA RESIDENTS

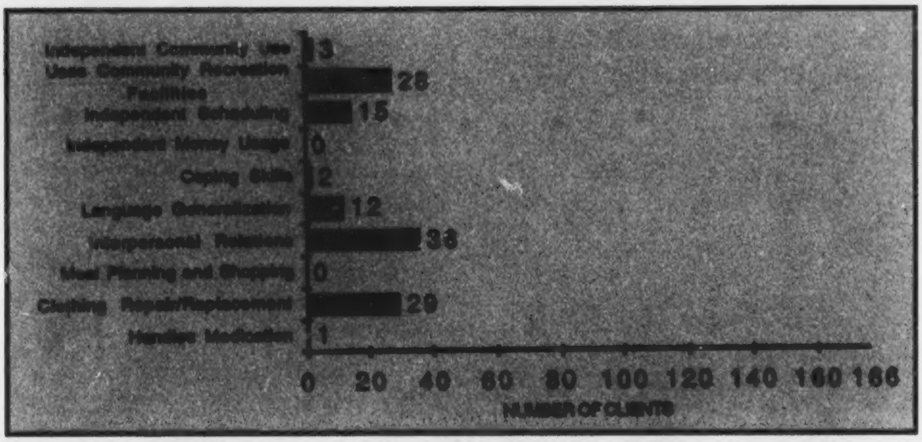

Figure 2.132: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE OF COLANDA RESIDENTS

2.4 REFERENCES

Schalock, R. & Gadwood, L., *Communtiy Living Skills Screening Test*. Hastings: Mid-Nebraska Mental Retardation Service, 1980.

Schalock, R. *Community Living Skills Screening Test Standardization Manual*. Hastings: Mid-Nebraska Mental Retardation Services, 1980.

Shalock, R. (Ed.), *MR/DD Services in Rural American . . . It is Time*. Washington D.C: Institute of Comprehensive Planning, 1979.

Shalock, R. & Harper, R. *Placement from Community-based Mental Retardation Programs: How well do Clients do?*. American Journal of Mental Deficiency, 1978, 83, 240-247

3. CLIENT CONSULTATION STUDY

During September and October 1987, members of the Ten Year Plan Project Team discussed the contents of the ***Interim Report of the Ten Year Plan for the Redevelopment of Intellectual Disability Services*** *with adult residents of State Residential Training Centres and sought their views on the proposals it contained as part of the Public Consultation Phase of the Ten Year Plan Project.*

This exercise was undertaken at the request of the independent Consultation Steering Committee since people living in institutions, in the main, did not appear to have ready access to consultation meetings or an opportunity to gain assistance in preparing submissions to the Steering Committee.

Most residential units in each State Residential Training Centre were visited and formal presentations given. In total, meetings were held at ten facilities, which were attended by approximately 2,400 adults with intellectual disabilities. More than 60% of the total adult population of these facilities subsequently took up our offer of assistance in preparing their response to the proposals made in the ***Interim Report****.**

Findings were submitted to the Consultation Steering Committee and analysed along with all other submissions.

This section describes the purpose, process and findings of this aspect of the Project Team's work.

3.1 THE PURPOSE

The primary purpose of this exercise was to ensure that adults with intellectual disabilities who resided in State Residential Training Centres had the opportunity to exercise their right to play a major role in the development and planning of intellectual disability services in Victoria as required under Section 5 (m) of the **Intellectually Disabled Persons' Services Act, 1986**.

A corollary of this main purpose was to ensure that the consultation process and materials generally available to the community at large during the course of the Public Consultation were adapted to enable access to this information by people with intellectual disabilities and that the actual service provided was tailored to meet their individual requirements where possible (Section 5 (f) of the **Intellectually Disabled Persons' Services Act, 1986.**).

3.2 METHOD USED

3.2.1 Settings and Client Group

Consultation meetings took place at all eight CSV/OIDS Training Centres and two of the three Office of Psychiatric Services Hospitals which have Training Centre wards. A presentation was not made to the 19 men who then lived in the Training Centre ward at Brierly Psychiatric Hospital as all had previously participated in detailed discussions relating to their service preferences and a separate report had been prepared and made available to the Study Team.

All adults in the above facilities were invited to attend presentations, and express their views. The process (see below) was geared to adults with intellectual disabilities thus children were not invited since it was beyond the scope of the exercise to ensure that each person under 18 years of age had a parent or guardian present.

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* Footnote: This process also included two additional presentations to 100 people who either lived in a Special Accommodation House or worked in a Sheltered Workshop in Bendigo. Data from this aspect of the exercise does not appear here, but was included in findings reported in the Consultation Report, 1988.

3.2.2 Officers Involved in the Consultation

The six people who conducted the consultation with clients were all members of the Ten Year Plan Project Team and hence very familiar with the content of the **Interim Report**. Three were Registered Mental Retardation Nurses with many years experience at the Charge Nurse level, one was an experienced House Supervisor from the Community Residential Unit (CRU) Programme, a fifth was qualified and experienced in the field of Early Childhood Education and the officer responsible for the conduct of the exercise was a Special Educator with many years direct service experience in the intellectual disability field. All were competent in communicating with people with intellectual disabilities in both verbal and non-verbal modes.

3.2.3 Materials Used During Presentations

Since most people living in CSV/OIDS Residential Training Centres had little knowledge of how non-institutionalized people live and few opportunities to get such information, limited reading skills and in some cases little receptive language, the following highly visual materials were used:

- **Video Material**

A 15-minute video film entitled "Out and About", prepared by the New South Wales Department of Health in 1986 was used to show residents the types of new living experiences they could expect when moving into the community. The video featured ex-residents of an institution in Sydney and gave a glimpse of their new life-style including some of the adjustments they needed to make. These people also discussed their personal feelings, perceptions and plans in relation to their return to general community life.

A second six-minute "Vocational Options" video depicting a programme in northern New South Wales employing people with mild/moderate intellectual disabilities in various real jobs in the local community was also used. Once again individuals shown in the video discussed their experiences, perceptions and feelings about themselves in relation to their new role as valued members of the community.

- **Written Material**

A pamphlet entitled **"Ten Year Plan for the Redevelopment of Intellectual Disability Services"** was developed by the Project Team so that each client could have individual access to the actual proposals presented in the **Interim Report**. The document displayed options in line drawings and simple sentences to ensure access to this vital information by people with limited or no reading skills.

3.2.4 Procedures

Consultation meetings involved a pre-arranged visit to each residential unit or living area by two or three Team members which lasted between 45 minutes and two hours depending upon the number of people in each unit and the number wishing to discuss their opinions and wishes with us.

Meetings followed a set format whereby the Team

- briefly described the Ten Year Plan Project, the **Interim Report** and the Consultation Process,
- showed the video, "Out and About",
- distributed copies of the pamphlet depicting the proposals contained in the **Interim Report** to each person present,
- lead discussion on each proposal and answered residents questions, and
- showed the six minute video on Vocational Options if residents' disabilities were within the mild/moderate range.

Once the formal presentation was completed, Team members invited residents to discuss their personal views in relation to the options described in the **Interim Report** on an individual basis. Each person was told that their views would be written down and guarantees were given that their comments would be considered along with all other submissions. It was however emphasised that new services and changes would take time to develop and everyone would be spoken to again before any moves occurred.

In recording each person's response, Team members used individual recording sheets to simplify analysis. If an option was not covered by the resident during the course of the conversation, or the Team member was unable to interpret the person's response, it was left blank and scored as a "no response".

Both verbal and non-verbal responses were recorded. In the case of a non-verbal response, the person needed to indicate a preference on three occasions for it to be recorded as a response. In many cases Unit staff assisted Team members in interpreting resident responses as did other more able clients.

Every attempt was made to ensure that an independent observer was present at each presentation. People from the Consultation Secretariat, Parents and Friends Associations and Community Visitors fulfilled this role. In addition, video and audio recordings of meetings were made by the Secretariat at random.

3.3 RESULTS

3.3.1 Access to Information and Opportunity to Make a Submission

As shown in Table 3.1, 85 presentations were made in ten Residential Training Centres across the State, providing at least some access to the contents of the **Interim Report** for approximately 2,400 people with intellectual disabilities living in Training Centres.

An important component of the process was played by many of the more articulate residents, and those that had some reading skills who were observed going through the written material and further explaining points to other residents.

Of the 2,300 adults with intellectual disabilities living in the CSV/OIDS Training Centres excluding Colanda and the two (2) joint OPS/OIDS facilities, 1348 (59%) elected to have their views on the options contained in the **Interim Report** recorded for submission to the Consultation Steering Committee along with other Victorians.

Data relating to the views expressed by residents of Colanda Training Centre at Colac are not available since responses were only recorded on audio tape and were too difficult to analyse due to excessive background noise. A second opportunity to prepare a response for Colanda residents could not, unfortunately be arranged due to time constraints.

Table 3.1: CONSULTATION SETTINGS AND CLIENTELE – TEN YEAR PLANNING PROCESS SEPTEMBER–NOVEMBER 1987

Facility	Approximate Number of Clients Residing at Locations of Consultation Presentations	Number of Adult Clients Who Gave a Response	Dates of Consultation	Number of Presentations Conducted
Kew Cottages	786	422	14, 16, 21, 26 & 27 Oct. & 4, 5 & 6 Nov.	26
Sunbury T. C.	627	405	9, 16, 19, 26 & 28 Oct.	20
Janefield T. C.	420	237	22, 27 & 29 Oct. & 5 & 6 Nov.	13
Colanda T. C.	174	NO DATA AVAILABLE	29 Sep.	7
Pleasant Creek T. C.	125	66	8 Oct.	2
Kingsbury T. C.	71	47	19 Oct.	4
Sandhurst T. C.	43	42	1 Oct.	1
Aradale T. C.	245	75	30 Sep.	6
St. Gabriels Centre	28	5	12 Oct.	1
Mayday Hills T. C.	143	56	2 Oct.	5
TOTAL	2662 less 250 (children) 2,412 (adults)	1348	29 Sep. – 6 Nov. 1987	85

Prepared by the Ten Year Plan Project Team
December 1987

Table 3.2: SUMMARY OF CLIENTS IN INSTITUTIONS SUBMISSION TO THE INTERIM REPORT OF THE TEN YEAR PLANNING PROCESS

Total Respondents by Centre	Sunbury	Kew	Pleasant Creek	Kingsbury	Janefield	St. Gabriels	Sandhurst	Colanda	Mayday Hills	Aradale	Totals
Response Category	405	422	56	47	237	6	42	NO DATA AVAILABLE	58	75	1348
1 Type of Accommodation											
a) Want to stay in Training Centre	42	14	5	2	25	—	3	NO DATA AVAILABLE	6	21	118
b) Want to live somewhere else	202	139	32	20	170	6	38		45	54	706
c) No response	161	270	19	25	42	—	1		7	—	525
2 Locality											
a) Want to live in city/suburbs	87	41	20	6	81	4	7	NO DATA AVAILABLE	2	8	256
b) Want to live in country/or farm	83	16	25	7	46	1	13		23	23	237
c) Don't know/doesn't matter/other	7	3	—	—	4	—	5		—	—	19
d) No response	228	362	11	34	106	1	17		33	44	836
3 Staffing Requirements											
a) Want help from staff	152	90	24	13	116	5	11	NO DATA AVAILABLE	16	21	448
b) Want help from others	136	77	36	10	105	3	1		3	13	384
c) Want no help	9	3	4	—	1	—	4		—	—	21
d) No response	214	310	11	28	74	—	26		41	51	755
4 Personal Preferences											
a) Want own bedroom	186	88	40	18	155	4		NO DATA AVAILABLE	2	30	524
b) Want to share bedroom	6	6	3	2	7	—			—	—	24
c) Want to have visitors in private	146	64	36	10	132	3			2	1	390
d) Want to do own cooking	166	94	40	19	152	5			4	4	482
e) Want to do own shopping	165	97	41	20	159	6			6	6	500
f) Want to choose own belongings	183	70	36	16	144	5			3	3	460
5 Employment											
a) Want help to find a job	156	100	41	16	120	2	25	NO DATA AVAILABLE	25	28	513
b) Want help to learn job	137	82	42	14	155	3	1		25	12	431
c) Want support at workplace	123	81	40	11	116	2	2		25	12	412
d) Like current job/workshop	2	7	—	2	10	—	—		—	1	22
e) Doesn't want/need to work	30	2	—	1	1	—	3		—	2	39
f) No response	213	312	10	28	104	3	11		33	44	758
6 Further Education											
a) Wants further education	112	48	33	9	65	2	—	NO DATA AVAILABLE	6	2	277
b) Doesn't want further education	14	11	—	—	25	—	—		—	—	50
c) No response	279	363	23	38	147	4	42		52	73	1021

3.3.2 Preferences of Training Centre Residents

Preferences stated by people living in residential institutions fell mainly into the six main categories summarized in Table 3.2. These cover preferred type and location of accommodation, perceived staffing requirements, the desire for personal privacy and independence, employment needs and access to further education.

As the table shows, the first category, "type of accommodation preferred", generated the most interest. Of the 1,348 residents who elected to have their views recorded, 61% (N = 822 people) discussed their requirements in this category. No response in this category was recorded for 524 people (39% of those making a submission) which includes people who did not comment on this aspect and those whose response the Team could not interpret with any degree of certainty. 118 people (9% of all those who elected to record a response) wanted to remain in the Training Centre. 706 people, or 52% of all those who spoke to the Team, wanted to live in community housing such as a house or a flat either with one or two friends or by themselves. Some suggested a farmhouse would be their preferred option. In many cases residents were very certain as to who they did and did not wish to live with. A typical response by a person with limited or no verbal skills would include pointing to the picture of a house, themselves and one or two other residents whilst nodding then pointing to other residents, one by one, and shaking their head vigorously.

A near equal desire for country (N = 237 people) and city (N = 255) locations was expressed by the 511 people who went into more detail by stating their preference in regard to the location of future community living. 19 people really didn't mind, typically stating both.

593 people gave their views on their perceived staffing requirements. Only 21 wanted no help whereas 448 wanted current staff to continue to assist them in their daily lives and 386 believed they would either require other people in addition to current staff or felt only other people would be required to help them in their new lifestyle.

Category 4, "personal privacy and independence" summarizes many of the comments made by residents as they discussed their desires and aspirations for the future. As shown in Table 3.2, the desire to attend to one's own basic needs was frequently mentioned.

Of the 590 people who appeared to grasp the concepts relating to employment, only 39 did not want to work, a number of whom pointed our that they were in fact now "aged pensioners" and had reached retirement age. Most (N = 515 people) stated that they needed help to find a job and 431 also felt that they required assistance in learning a job. The perceived need for continuing support at the workplace was also mentioned by a significant number of people (N = 409). Although the data relating to the number of people who actually had jobs is not known, only 23 reported that they were happy with their current employment.

During the course of individual discussions with Team members, many residents pointed out the importance of work to them and how access to a means of earning their own money would greatly enhance their independence and dignity. Many gave details of the type of job they believed they could do, given assistance.

Responses relating to further education were mixed: some people had a clear idea of their requirements whereas most sought information as to types of courses available. Some emphasised that they were no longer children so would not attend school, but thought "night school" could possibly meet their requirements in terms of learning new job-related and hobby skills.

3.4 DISCUSSION

The findings of this exercise indicate that a significant number of people with intellectual disabilities who live in State Residential Training Centres see access to community housing, employment and further education for people now residing in Training Centres as key issues in the redevelopment of Intellectual Disability Services in Victoria.

The realistic and carefully thought-through views relating to the services required to ensure a decent lifestyle expressed by these clients of CSV/OIDs clearly demonstrated the importance of ensuring that they play a major role in the overall planning of Intellectual Disability Services if, indeed, these services are to meet needs of consumers. (i.e. Section 5(m), Intellectually Disabled Persons Act, 1986)

The importance of attending to Section 5(m) of Intellectually Disabled Persons Act, 1986 was highlighted in this exercise. For example, the often expressed desire to live with only one or two people with whom they have long-standing friendships, indicates that who one shares a home with is a very personal matter for these people, many of whom have lived in congregate care most of their lives. This is not, of course, common practice in the Community Residential Programme where "vacancies" are filled from a waiting list.

In the course of this exercise a number of points relating to the procedures we used in our attempt to adapt the Consultation process and materials so as to better meet the needs of people with intellectual disabilities (i.e. Section 5(f) of the Intellectually Disabled Persons Act, 1986) also emerged.

Our attempt at using audio-tapes of meetings, a normal practice in the Public Consultation meetings, was not successful. This method was used at Colanda and resulted in no usable data since background noise made it difficult to understand resident responses. During meetings it also presented difficulties as some residents were distracted by the tape recorder.

The two video tapes depicting people with intellectual disabilities in their daily lives were very successful in conveying the issues and in generating discussion in most cases. "Out and About" was also narrated by a person who used to live in an institution in Sydney which appeared to be an added advantage. This form of presenting material of importance to people with intellectual disabilities seems to have considerable potential and, in our view, should be extensively developed and carefully evaluated to ensure that Victorians with intellectual disabilities are kept up to date on matters of vital interest to them.

The written pamphlet distributed to all people attending meetings was successful in conveying options to many present and was certainly highly valued by the more articulate residents who used it in their own discussions with peers. However, some people, especially those with more severe disabilities did not appear to interact with the line drawings at all. We therefore believe that the use of photographs depicting people with disabilities would have been a more successful medium for this purpose.

In general, residents were very eager to take up our offer of assistance in preparing their submissions and Team members noted the amount of thinking and discussion residents had obviously done surrounding possible community living. A certain sense of frustration was however felt by all Team members in their own inability to interpret the responses of some people with severe communication difficulties. Unit staff and more articulate residents were of considerable assistance in many instances and future studies of this nature should examine very carefully the possibility of including local staff and resident representatives on study teams.

4. THE PREVALENCE OF INTELLECTUAL DISABILITY IN VICTORIA

The purpose of this Working Paper is to provide a basis for assumptions that will need to be made in the client projection model for the OIDS Ten Year Plan for Services Redevelopment. Preparation of a client projection model requires that a number of assumptions have to be made regarding the prevalence of intellectual disability in the community. Furthermore, this prevalence has to be broken down by age, sex and degree of disability.

A great deal of literature, the majority of it from overseas, has already been accumulated. It is not intended to add to that literature, rather this literature has been reviewed so that sensible assumptions regarding the Victorian situation can be made.

Overall, the findings of this Working Paper are that the True Prevalence Rate in Victoria is probably in the order of 1.0%. However, the incidence of intellectual disability amongst new born children has declined significantly in the past two decades, therefore the True Prevalence will decline in coming years. The estimate suggests that while OIDS have made contact with the great majority of persons with a severe or profound intellectual disability, it has contacted about 70% of those with a moderate intellectual disability and less than one in ten of those with a mild intellectual disability. This has significant implications for future client numbers if a wider and less institutionally orientated range of services is offered by OIDS in the future.

4.1 OVERALL PREVALENCE OF INTELLECTUAL DISABILITY

Prevalence relates to the estimates of the number of persons with a intellectual disability in the total population. This is said to range from under half of one percent to three percent of the total population overseas and in Australia. The variation occurs because of:

- different definitions of intellectual disability;
- characteristics of the community; and
- methodology adopted for the identification of such.

4.1.1. Different Definitions of Intellectual Disability

The definition of intellectual disability varies. For example, during the history of previous prevalence studies the definition of "mild" intellectual disability has altered. Also those persons with a so called borderline intellectual disability are not consistently included or excluded from the figures thus affecting the prevalence rate. This inconsistency has been found in Australia—compared with Western Australia and South Australia, Victoria tends to exclude some such cases, hence the prevalence rate is lower.[1] Victoria uses the American Association of Mental Deficiency (AAMD) definition, and this has formed the basis of data classification in this paper.

It is also noteworthy that if the intellectual disability is only measured according to the IQ assessment or cognitive functioning the rate will be relatively higher. In other words a one dimensional definition is not necessarily accurate. A large number of writers have identified other factors, such as, adaptive behaviour, 'social adequacy', or the economic and social characteristics of the environment that can also affect the prevalence rate.

Further, the Onondaga Study et al (1965) also identified a range of factors which affect the prevalence rate. To quote:

1. medical, e.g. evidence of organic brain disorder;
2. psychometric (I.Q. less than 75);
3. poor social adaptation and behaviour disorders;
4. academic lag of one or more years; and
5. family history.

As can be seen from the above, a number of factors affect the definition and in turn measurement of intellectual disability. In fact, there are often other complications. It can also be said there is some overlap at times, that is, those who have only social behaviourial difficulties or difficulty with learning are often included as having an intellectual disability. They may not have any intellectual impairment but are not able to succeed at school or elsewhere, hence in some instances they are considered to possess an intellectual disability.

4.1.2 Characteristics of the Community

Age distribution and other demographic factors also effect the number or prevalence of persons with an intellectual disability. For example, it has been found that:

- a higher number of intellectually disabled persons are in the school age bracket; (see Section 2.3)
- intellectual disability appears to be more prevalent amongst males than females; (see Section 2.3.)
- mild intellectual disability appears to be associated with lower socio-economic status; (see IOWA Comprehensive State Plan) and
- differences occur in prevalence in rural and urban areas.

The prevalence of at least the more severe levels of intellectual disability are likely to be underestimated among the younger age groups because of the higher mortality rates among these persons with such a severe impairment. Conversely, the prevalence is likely to be overestimated among the older age groups because of these mortality rates. However, as stated by Kraus and other researchers, the prevalence of the milder levels of disability is likely to be more adequately represented by the prevalence observed in school age children.

Most studies reveal that males with intellectual disabilities outnumber females in a ratio of 3:2. The discrepancy is particularly noticeable in the lower age categories. Further, the research also demonstrates that the prevalence of mild intellectual disability in particular is found to be higher among groups of lower socio-economic status. And, the level of acceptance and in turn the demands placed on individuals or expectations in terms of intellectual ability, could also differ between rural and urban areas.

4.1.3 Methodology Adopted for the Identification of Prevalence of Intellectual Disability

A range of techniques have been employed to estimate the prevalence of intellectual disability. If a *theoretical* approach is taken it is assumed that intelligence is normally distributed, the mean is 100, and that anyone intellectually disabled falls below and IQ assessment of 70 on the psychometric scale, that is, 2.0%–3.0% of the total tested population.[2] Further, this approach also demonstrates that the degree of disability varies. Persons are considered to have a mild intellectual disability if their IQ is in the 50–70 range; while moderate falls between 35–49; severe between 20–34 profound between 0–19.

This method of extrapolating prevalence figures using this theoretical method alone is highly questionable because:

- the defining criteria of impaired adaptive bahaviour (what people do to take care of themselves and to relate to others in their every day life) is ignored;
- it is assumed that intellectual disabilities are identified in infancy when in fact mild intellectual disability is usually not established before school age;
- the assumption that diagnosis does not change ignores many individuals diagnosed as intellectually disabled during school years who wore this label as adults.
- it assumes morbidity of intellectually disabled people is similar to that of the general population when in fact the life expectancy of severely intellectually disabled individuals is well below that of the general population.[3]

Moreover, it does not allow for the differences in age and socio-economic characteristics. As already stated, intellectual disability is generally held to be more prevalent among males and members of lower socio-economic groups, while profound intellectual disability is distributed fairly randomly through all socio-economic groups and is not related to any parental disability.

If a more *empirical* approach is adopted, a range of techniques are used:

- extracting information from agency records;
- collecting information from key informants in the community; and
- census and sample surveys of households in a given population.

Although, this approach is based on counting actual persons, it also has some disadvantages. It is still difficult to obtain the 'true' prevalence of the intellectual disability in the population. Collecting the information from agency records only provides a measure of ascertained prevalence, that is, only those who have perceived the relevance of available services and have registered. Persons with a mild intellectual disability are therefore often omitted. Moreover, the numbers of persons registered may be a reflection of the popularity of the existing range of services.

As can be seen from the above, there are limitations in both methods. The determination of 'true' prevalence is difficult to obtain as there is a zone of uncertainty that has to be calculated.

Tizard (1964) proposed a useful classication of prevalence. He differentiated between 'true', 'administrative' and 'ascertained' prevalence of the intellectual disability.

> **'True' prevalence**, as indicated above, is the total number of persons with an intellectual disability in the population, that is all persons, those who require special services as well as those who don't.
>
> **'Administrative' prevalence** relates to those persons with an intellectual disability who require services. In other words, they are generally those who are registered with a service of agency and are in need of the services.
>
> **'Ascertained' prevalence** refers to those who are brought to the notice of the responsible agency.

4.2 A COMPARISON OF PREVALENCE OF INTELLECTUAL DISABILITY

4.2.1 Overall Prevalence Rates

Comparisons of prevalence rates are difficult to make because of the different ways adopted by various agencies in collecting data and identifying clients. As already stated, the empirical approaches to estimating prevalence involve a number of techniques. Further, it is not always possible to differentiate between the 'true', 'administrative' and 'ascertained' prevalence. Many persons with a 'borderline' or 'mild' intellectual disability are not registered or brought to the notice of the responsible agencies.

It is also noteworthy that the following discussion does not give a direct comparison between the Australian States and overseas, as figures for each have not been collected for similar years, nonetheless the figures are indicative.

In June 1985, some 11,793 clients were registered with the then Victorian Division of Mental Retardation, this represented an administrative prevalence of 0.286%. As stated by Cocks, this data base demonstrates an underestimation of prevalence. For example, it excludes the number of children and adults with an intellectual disability who are clients with the Education Department in special schools or special development schools. This accounted for 3,706 persons at that time. Only 591 of these were included, leaving 3,115. When added, the identified population then becomes 14,908 which represents a prevalence rate of 0.362% or 3.62 persons per 1,000 of the general population. This rate compared with other States (even though figures are not directly comparable) is relatively low. To illustrate:

	(Ascertained)
Western Australia	0.440%
New South Wales	0.456%
South Australia	0.440%

Furthermore, relative to some overseas estimates (for example, Iowa U.S.A) the Victorian estimate in particular is significantly lower. In 1982, Iowa's estimated incidence rate, based on the psychometric measurement alone, was 30 per 1,000 or 3% of the total population. This was much higher than when utilization data for Iowa was examined. A major reason why ascertained rates are always well below an expected psychometric rate of 3% is that the severely and profoundly intellectually disabled have higher mortality rates. Furthemore, the persons with a mild intellectual disability can adapt to their environment to the point that they no longer require specific services.

Other researchers, Mercer et al., found that less than 1% (0.9%) of the population had an intellectual disability in California. A Connecticut study also supported the 1% estimate. A study in England estimated that 2% of the population had an intellectual disability but they could account for only one third of those at any one time using the services and facilities. In other words, as indicated above, exact prevalence figures are not possible, nor are they comparable between different countries or different locations.

4.2.2 Prevalence by Degree of Intellectual Disability

As already suggested, not all persons with an intellectual disability register. Further not all are formally assessed. Hence accurate figures on the the prevalence of intellectual disability are difficult to obtain. For example, in Victoria only 26.5% of cases were assessed, 57% were estimated and no information was noted for 16.5%. A similar ratio occurred in South Australia. The figures therefore again must be treated as approximates only. Table 4.1 demonstrates the variance between the States.

Table 4.1: NUMBER OF PERSONS WITH AN INTELLECTUAL DISABILITY AUSTRALIAN STATES BY LEVEL OF DISABILITY

State Level of Handicap	Victoria Jan. 1985	West Australia Dec. 1982	South Australia Mar. 1981
Borderline	920	1,070	824
Mild	2,392	1,825	1,986
Proportion	24.60%	32.30%	30.10%
Moderate	3,298	1,312	1,909
Proportion	31.10%	23.20%	28.40%
Severe	1,382	637	871
Proportion	11.70%	11.30%	13.20%
Profound	798	253	397
Proportion	6.80%	4.80%	6.00%
Unknown	1,862	563	580
Proportion	15.80%	9.90%	8.80%
Total	10,800	5,650	6,600
Overall Prevalence	[illegible].26%	0.44%	0.50%
State Populations	4.12m	1.28m	1.29m

Sources: (1) Mental Retardation Division.
Health Commission of Victoria Vol.2. No. 2, June 1983
(2) Office of Intellectual Disability Services Client Data Base (1985).

In other words, the prevalence rates for Victoria are "ascertained" only. Western Australia and South Australia show numbers of clients from a wider range of service bodies, hence you would expect them to be higher. None of the Australian figures can be considered to be True Prevalence Rates. The nearest to this are the results of an Australia wide sample household survey by the Australian Bureau of Statistics in 1981. This indicated a prevalence rate of 0.76% but many persons could have been missed due to the answers being based on self analysis or assessment by non qualified interviewers. In the school age group of 5 to 14, the prevalence rate was put at 1.39%.

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Other studies have attempted to establish the "true" ratio between the four levels of intellectual disability. These have varied greatly because the mild intellectual disability is the most difficult to estimate because not all persons register. Past estimates of the ratio of Mild to Moderate to Severe/Profound have been:

Iowa (1985)	29	4.7	1
Krupinski (1963)	9.3		1

Ratios of Mild to Moderate/Severe Profound have also been estimated.

Wood Report (UK) 1929	4.9	1
Lembou (US) 1936	12.2	1
Goodman & Tuyard (UK) 1962	2.9	1
Krupinski (Australia) 1963	2.25	1
Clarke & Clarke (UK) 1974	3.0	1
Jackson (UK)	10.0	1
South Australia (1981)	1.5	1
Iowa (US) 1983	5.0	1

A significant fact from the above ratios is that the Australian ratios of Krupinski and South Australia are significantly lower than overseas examples. That is to say, in Australia we seem to have a lower proportion of persons with a mild intellectual disability.

This, together with the fact that the Australian ascertained prevalence rates are comparatively lower can be explained by:

(a) Australia has a highly controlled population in that overseas born persons (23% of the population) were screened to some extent for intellectual disability at the time of immigration entry. This could also have some impact on the incidence of intellectual disability in their offspring (a further 23% of the population).

(b) Australia does not have a significant strata of society with a preponderence to be in depressed socio-economic conditions and characterised by a biased ethnic base such as happens in the USA or even parts of Europe. Poverty has been shown to be highly correlated with the incidence of mild intellectual disability.

For these reasons, the Krupinski and South Australian data probably represent the best available picture of the relative ratios between categories in Victoria.

It is generally held that the incidence of mild intellectual disabibility is correlated with environmental conditions such as poverty, general health standards and education. On the other hand, the moderate, severe and profound categories are more related to hereditary, genetic and prenatal factors.

For this reason, it is not surprising to find a remarkable similarity in the combined prevalence rates for the severe, profound and moderate categories in various studies around the world. As can be seen, the rate has generally been put somewhere between 0.35% and 0.40%.

Location	Researcher	Year	Ascertained Prevalence
USA	Shirley	1963	0.40
Wessex	Kushlich	1963	0.35
Salford U.K.	Kushlich	1963	0.36
Middlesex	Tizard	1962	0.35
Finland	Amnell	1964	0.35
Queensland	Reynolds	1976	0.34
Western Australia	Division for I.H	1981	0.21
South Australia	IKP Project	1981	0.29

Source: Final Report on the Intellectually Retarded Persons Project S.A. Vol. 3 and Kraus (1973).

Two conclusions can be drawn from these rates:

- they decline as more recent studies are quoted suggesting a decline in incidence; and
- the Australian rates are lower. This is likely to be due to the two reasons discussed earlier together with the fact that the ascertained prevalence may be lower due to a low contact rate with service agencies.

4.2.3 Prevalence of Level of Intellectual Disability by Age and Sex

As already indicated, most studies demonstrate that the proportion of the population with an intellectual disability is generally concentrated in the school age and immediately post school age years from 5 to 19. It is at this age that many children with a mild intellectual disability come to the attention of agencies due to poor academic performance. The thorough studies carried out in South Australia showed that the ascertained prevalence peaks at 0.93% in the 15–19 age bracket, it declines steadily thereafter to 0.45%, then follows a plateau level of between 0.14 and 0.18%.

In Victoria, a similar picture emerges with the highest concentration of OIDS clients being found in the school age group of 6 to 16 years. This group represents about 17% of the population but accounts for 20% of OIDS clients. In addition to the school age children on the OIDS clients list there are 3,115 children in Education Department facilities identified as having an intellectual disability.

Allowing for Education Department clients it is also noteworthy that the majority of those with mild and moderate intellectual disabilities are in the school age and immediate past school age groups. Persons with severe and profound intellectual disabilities are also concentrated in the school age groups, but the concentration is even more pronounced. (Table 4.2)

Table 4.2: OFFICE OF INTELLECTUAL DISABILITY SERVICES DEGREES OF INTELLECTUAL DISABILITY (%) (1985)

Age Group	Mild	Moderate	Severe	Profound		
0	—	5	2.1	1.4	3.6	2.1
6	—	20	10.5	12.8	14.2	14.6
21	—	40	54.9	44.7	41.4	57.8
41	—	30	13.8	14.5	13.7	8.1
60+	—	5.7	4.1	3.0	1.2	
Total %	100.0	100.0	100.0	100.0		
No.	2,320	3,823	1,378	793		

Source: OIDS Computer Records of Client List.

There are a number of reasons why this skew in the distribution of absolute numbers and prevalence rates occurs across the age profile:

- People with intellectual disabilities, especially mild ones, are most likely to be detected during school age years.
- Pre-school age children may go undetected, especially at the mild and moderate levels.
- There is also the issue of adaptive bahaviour to consider. Many persons with a mild intellectual disability may acquire sufficient skills by the end of schooling to merge into the community and lose the "tag" of being intellectually disabled.
- Once a person with a mild intellectual disability has left school they may tend to drift away from specialist services because they develop a desire for independent living, and /or they want to avoid any "stigma" of being labelled as intellectually disabled.
- Persons with a Severe and Profound intellectual disability tend to be skewed towards a concentration in lower age groups because of these persons relatively high mortality rates.

In terms of sex, as already noted intellectual disabilities are much more prevalent among males. And the degree of disability varies accordingly. Again the South Australian survey shows this clearly:

Table 4.3: ESTIMATED DEGREE OF INTELLECTUAL HANDICAP

Degree of Intellectual Handicap	Male	Female	Sex Unknown	Total	Percentage
Mild	1,087	858	23	1,968	38
Moderate	1,038	801	26	1,868	37
Severe	470	380	5	861	17
Profound	193	193	1	387	8
Unknown	308	232	21	560	adjusted (N = 5116)
Total	3,140	2,444	8	5,678	100

The discrepancy between the males and females is most noticeable in the lower age brackets (for example, South Australia 0–4 years, 60% males and 39% females). The greater number of males to females, is due in part to the fragile X factor, and the social customs whereby it is more acceptable for adult females to remain at home and therefore less inclined to be registered. It is also noteworthy that males are expecially more prominent in the mild and moderate categories of intellectual disability.

4.3 PRESENT AND PROJECTED TRUE PREVALENCE IN VICTORIA

As mentioned in Section One of this paper, the measurement of true prevalence can be undertaken by either a theoretical/psychometric approach principally using IQ data, or by empirical observation. Both methods have their drawbacks, but most studies have tended to choose the empirical observation approach.

However, there seems to be two major problems with the empirical approach which relies on existing client data amongst existing service organisations.

- The number of clients may be as much a reflection on the type of services offered as the level of true prevalence. Given that the task of this study is to examine service re-organisation at OIDS, it would be unwise to base prevalence estimates purely on existing client data. Existing clients registered for services that were highly oriented to one type of service that may not be the thrust of OIDS in the next ten years. Consequently a whole new client group could emerge with the provision of new services.
- There has been a dramatic change in the parameters affecting the incidence of intellectual disabilities amongst new born children therefore the present client profile spans a wide range of historical incidences rates. For projection purposes it is necessary to understand the changing level of incidence and make allowance for it when estimating true prevalence.

4.3.1 Adopted Approach

For these reasons, a modified form of empirical observation has been used. Essentially the approach has been to start with the existing client data and then using that part of it which is thought to be closest to true prevalence, by using a number of demographic assumptions.

In a sense, the approach is similar to that used by the Archaeologist, except on this occasion it is a population that is being reconstructed using the existing portions of the population that have so far been enumerated.

4.3.2 True Prevalence in School Age Children

The first step was to recognise that the existing OIDS and Education Department data on clients with an intellectual disability was probably most closely reflective of the true prevalence rate in the case of:

(1) Persons with a Severe and Profound intellectual disability; and

(2) Children of school age, and possibly in the instance of the severe and profound levels, the immediate post school years.

As at June 1985 there were 2,540 clients within the school age group of 6 to 16 years registered with OIDS. Of these, 61 were classified as borderline, and 554 as other, the latter generally not having an intellectual disability. Consequently, when the remaining 1,925 clients are added to the 3,275 Education Department clients not already included in the OIDS client list, the result is a total of 5,200 school age children with a known intellectual disability as at June 1985.

Given that as at June 1985 there were an estimated 728,400 children aged 6 to 16 years in Victoria, the ascertained prevalence rate was 0.71%. With all of the skills and techniques now operating in the Education system for the detection and teaching of persons with an intellectual disability, it is probably reasonable to assume that the 5,100 registered OIDS and Education Department clients represent the great majority of all intellectually disabled of school age in the community.

For the purpose of this study, it has been assumed that the true prevalence rate for 6 to 16 year olds is 0.89%, that is to say the known clients represent 80% of all persons with an intellectual disability in that age group.

4.3.3 Severe and Profound Intellectual Disability

The second step is to build up a profile of persons with a severe or profound intellectual disability on the OIDS client list. For this purpose, the OIDS client list as at June 1985 was used with all clients on whom there was no information being distributed proportionally across the disability classifications.

This produced an Ascertained Prevalence Rate of ranging from 0.12% of the population for 17 to 20 year olds down to only 0.022% for pre-school age children. (Table 4.4). Based on these Ascertained Prevalence Rates, the True Prevalence Rate was assumed for each age group.

Producing a profile of age specific True Prevalence Rates required a combination of assumptions and testing with a simple mortality survival model. *The key assumption was that immediately after the school age years the detection rate (ratio of ascertained to true prevalence) for persons with a severe and profound intellectual disability would be very high, and it would almost be a 100% thereafter.*

As can be seen from Table 4.4, using this assumption and the other assumption regarding mortality and declining incidence, produces and estimated overall True Prevalence Rate of about 0.079% for severe and profound intellectual disability in the overall population.

When constructing the Age Specific True Prevalence Rates persons with a profound or severe intellectual disability, it was necessary to make assumptions about their mortality rates. The only detailed data on mortality comes from Kraus (1973) and his data is limited because it is over 15 years old and is only based on those persons in N.S.W. residential institutions. For this reason, the Kraus mortality rates are likely to be much higher than present rates.

As a consequence, it was necessary to assume a set of mortality rates. These together with the Kraus rates and general population mortality rates are set out below. (Table 4.5)

Table 4.5: MORTALITY RATE FOR PERSONS WITH SEVERE AND PROFOUND INTELLECTUAL DISABILITY
(Deaths per annum per 1,000 persons)

Assumed		Kraus	Approx. Rate for General Population
0– 4	100	—	10.0
5–10	80	—	0.3
0– 9	—	150.0	—
10–19	—	50.0	1.1
20–29	—	51.4	1.0
30–39	—	47.4	2.0
11–40	40	—	—
40–49	—	65.0	5.3
50–59	—	80.7	14.3
41–60	80	—	—
60+	100	107.1	80.0

Table 4.4: ESTIMATED TRUE PREVALENCE RATE OF SEVERE AND PROFOUND INTELLECTUAL DISABILITY IN VICTORIA JUNE 1985 (PERSONS)

Age Range	Victorian Pop'n June '85	OIDS Severe Profound Client	Ascertained Prevalence Rate	Estimated True Prevalence	Estimated No. Severe & Profound	% Estimated to be Profound	Estimated No. of Severe	Estimated No. of Profound
0–5	359,000	76	0.021%	0.158%	570	25	430	140
6–16	728,400	532	0.073%	0.124%	900	21	715	185
17–20	283,200	340	0.120%	0.120%	340	37	214	126
21–40	1,321,500	1,125	0.085%	0.086%	1,140	44	640	500
41–60	850,100	258	0.030%	0.031%	265	20	210	55
60+	579,300	54	0.009%	0.010%	55	20	44	11
Total	4,121,500	2,385	0.058%	0.079%	3,270	31	2,253	1,017

Source: Calculations by OIDS Ten Year Plan Team

As stated previously, it was assumed that almost 100% of those in the severe and profound categories had been detected by the time they were aged 17–20. As a consequence the application of the assumed mortality data to the detected number of 17 to 20 years old should have enabled the true prevalence rates for 0–5 and 6–16 year olds to be established.

However, when the assumed mortality rates and the old Kraus mortality rates are applied to the 17 to 20 year olds to recreate a population, the results indicated other factors were in operation.

Table 4.6: ESTIMATE OF POPULATION USING ALTERNATIVE MORTALITY RATES

Age Group of Persons with Severe & Profound Detection for Disabilities	Estimated Pop'n Nos. using new Rates	Estimated Pop'n Nos. using Assumed Mortality Rates	Estimated Pop'n Assuming 100% Kraus Mortality 17–20 year olds & 100% thereafter
0– 5	1,210	2,025	?
6–16	1,320	1,520	?
17–20	340	340	340
21–40	1,070	965	1,140
41–60	400	280	280
60+	100	65	54

The reasonably close correlation in the numbers of persons aged over 40 years between the estimated population based on the detection rates and the resultant numbers using the Kraus mortality rates, confirms that this older population has probably been fairly closely estimated using a 100% detection rate assumption. These older persons in the past would have been subject to the higher mortality rates hence their numbers are less than the new lower mortality rate assumptions would produce. The numbers aged 21 to 40 are slightly higher under the new mortality rates than under the Kraus rates. This would be in line with this group benefiting from some but not all of the improved survival rates of the last two or three decades.

Of particular interest however is the 6 to 16 age group. Under either the Kraus or new models mortality rates there should be some 1,300 to 1,500 persons in this age group. However OIDS has only about 530 clients with a severe or profound intellectual disability that are aged 6 to 16 years. Even allowing for Education Department clients, it is most unlikely the true numbers in this age group is more than 1,000 persons. Even that number would represent a suprisingly low detection rate.

Under the new mortality data , it would appear (even after allowing a declining birth rate in the overall population) that there has been a decline in the incidence of new born with severe and profound intellectual disabilities. The decline appears to have been in the order of 50% to 60% over the past 20 years, and must have mainly occurred between 1969 and 1979 which is the years of birth for the 6 to 16 year olds.

While such a large decline may at first seem hard to accept, it becomes more plausible when the factors operating on a reduced incidence rate are examined. These are discussed in the next section.

If such a large decline in the incidence of severe and profound intellectual disability is accepted, the question relevant to the projection of future client numbers is, has the decline continued since 1979? Generally the aswer is probably yes, but when the nature of the factors that reduced the incidence are examined, it is possible to say the greatest declines had probably already happened by 1979. For example, by then the use of rubella injections was well entrenched and the contraceptive pill widely used amongst high risk groups such as teenage girls.

Consequently, this paper assumed a decline in the incidence rate (at birth) or 2% per annum from 1965 to 1968, 5% from 1969 to 1980, and 3% thereafter. If these declines in incidence rate are combined with the assumed mortality rates, the result is Table 4.7 which shows:

- an estimated 570 persons with a severe and profound intellectual disability in the 0–5 year age group and 900 in the 6 to 16 year age group:
- a detection rate of 13% for the 0–5 year age group; and
- an incidence of 120 births where the child has a severe or profound intellectual disability in 1985.

4.3.4 Factors Acting to Reduce Incidence

Although there are a number of factors at work, there seems to be general agreement that the most important causes leading to a long run decline in incidence are:

- continuing reduction in birth rate among high risk groups;
- preventive health services to high risk groups;
- increased legalisation and practice of abortion;
- improvement of health and preventive services generally;
- general environment betterment; and
- early childhood education (Wolfensberger 1978).

Reduced Birth Rate Amongst High Risk Groups

The introduction of new contraceptive devices has resulted in a decline in the crude birth rate from 22 births per 1,000 in 1965 to 15.0 in 1980. The greatest decline occurred between 1970 and 1979, since then, the birth rate has slightly recovered.

Most importantly, new contraceptive techniques have enabled a greatly reduced birth rate amongst the "high risk" groups more inclined to give birth to an infant with an intellectual disability. Particular importance are very young mothers. Between 1954 and 1972 the birth rate for 15 to19 year olds in Victoria was about 40. Between 1972 and 1982 the rate declined to 19 with the largest decline happening in the early seventies.

Peventive Health Sevices to High Risk Groups

Concordant with the overall lowering of the number of births of infants with an intelletual disability, there has also been a drop in the neo-natal and infant mortality rates. Between 1971 and 1982 neo-natal deaths dropped from 10.4 to 7.1 (per 1,000 births) and infant deaths declined from 14.7 to10.7 (per 1,000 births). The medical advances causing this have also meant a lesser chance of underweight and premature babies being exposed to the possibility of intellectual disability. Of prime relevance to the severe and profound categories has been the development of pre-natal diagnosis of foetal abnormalities for "high risk" and other mothers.

Increased Legalisation and Practice of Abortion

As stated by Wolfensberger, and applicable to Australia, a significant proportion of severely and multiply impaired infants are products of hereditery, genetic and intrauterine damage. In many cases, with the more sophisticated health services, the presence of such damage can be suspected and increasingly even confirmed pre-natally. And as the practice of abortion in 'high risk' pregnancies, particularly the over 35 age group, becomes more widely accepted, the impaired infants are likely to decline even further.

Improvement of Health and Preventive Services

Improvement in health services are likely to continue to play a significant part in the overall decline in the true prevalence rate. In addition, some preventive services will also continue to contribute to the decline. For example, the introduction of rubella and measles vaccination as well as genetic counselling, pre-natal diagnosis of foetal abnormalities and so on will create greater awareness of possible problems among the 'high risk' groups in particular.

The above discussion demonstrates that there have been a number of factors which have affected the incidence rate of the intellectual disability. Advances in medical science have particularly reduced the prevalence of the 'profound' and 'severe' levels of intellectual disability, while social and education programmes are likely to have had some effect on lowering the prevalence rate for the 'mild' and 'moderate' categories.

Furthermore, the history of medical advances, contraception, legalised abortion, and preventive health services, is consisitent with the greatest decline happening during the seventies decade. Consequently this history is compatible with the suspected decline in incidence of the severe and profound intellectual disabilities observed earlier.

4.3.5 Mild and Moderate Intellectual Disability

Having derived a reasonable estimate of the True Prevalence of severe and profound intellecual disabilities, the next stage was to construct the rest of the population in the mild and moderate categories. This was achieved by:

- Adopting a ratio (based on past observation) of the relative occurrence of moderate intellectual disability to severe and profound intellectual disability with in the prime detection age group (6–16 years). Estimate a similar ratio for mild to all other categories.
- Allowing for the differential mortality rates with the severe and profound range and the mild and moderate range, adjust the adopted ratio for 6 to 16 olds so that an overall true prevalence rate of 0.89% is achieved for that age group.
- Allowing for mortality adjust, the adopted ratio for 6 to 16 year old groups to other age groups and apply it to the estimated true prevalence numbers in the severe and profound category in each age group.

For this analysis it was assumed that persons with a mild intellectual disability have a mortality rate the same as that of the general public. Persons within the moderate level were assumed to have the following annual mortality rate which tends to be about one third of the level of that for persons with the severe and profound levels.

0– 5	30/1000
6–16	20/1000
17–20	20/1000
21–40	30/1000
41–50	30/1000
51–60	50/1000
60+	100/1000

The major problem in this stage of the analysis is in fact selecting appropriate ratios between the different categories of intellectual disablity. As was discussed in Section 2 of this paper, there is a great variation in the ratios observed or estimated by previous writers.

The most comprehensive previously researched set of ratios in Victoria was undertaken by Krupinski in the early seventies. However, these ratios which were based on observations amongst school age children will reflect mortality rates and incidence rates for persons born in the period 1955 to 1965. As noted previously there have been considerable advances in health and preventative care since then.

For these reasons, it was decided to adopt the more recent South Australian ratio of 1.7 for the Moderate to Severe/Profound levels at the 15 to 19 age group because the South Australian data was comprehensively collected from a wide variety of services. In Victoria, the OIDS client data base provides a ratio of 1.4 for moderate to severe/profound. Allowing for a greater loss of detection amongst persons with a moderate intellectual disability, the 1.7 ratio seems a reasonable assumption.

The most difficult assumption is the ratio of the mild category to moderate/severe/profound as the true prevalence of persons with a mild intellectual disability has been so widely estimated in the past. Krupinski has suggested is was in the order of 2.5 to 1 for school aged children in Victoria in the early seventies.

The earlier analysis suggested that true prevalence of intellectual disability in school age children was about 0.84% if an overall detection rate of 80% was assumed. Given an estimated 900 persons age 6–16 with a severe or profound intellectual disability, and a further 1,260 with a moderate moderate intellectual disability (if the 1.7 ratio for moderate to severe/profound is adjusted for mortality) this should have 4,320 persons aged 6–16 with a mild intellectual disability. Thus under the assumption of a true prevalence rate of 0.89% for school aged children, the ratio of mild to moderated/severe/profound is 2:1 for that age group.

Interestingly, when these ratios between levels are applied to the Victorian population age 6 to 16 years, the result is an estimated true prevalence of 0.30% for the moderate, severe and profound levels. This would appear to be in line with observed prevalence in other places discussed on Page 11.

These ratios were then calibrated for other age groups after allowing for the differing mortality rates between the different levels of intellectual disability.

4.3.6 Estimated True Prevalence in Victoria

Application of the above method of estimating the number of persons with a mild and moderate intellectual disability produces an estimated True Prevalence Rate of 0.97% in Victoria as at June 1985. (Table 4.7)

It is important to note that the age specific True Prevalence Rates vary considerably from a peak of 1.13% in the 17 to 20 age group down to 0.76% amongst very young children. True Prevalence is estimated as also being relatively low in pre-school and school age children due to the advances in health, general environment and education discussed earlier.

Use of the estimation method described in this report suggests that altogether there are almost 39,800 persons with an intellectual disability in Victoria. Of these 78.3% have a mild disability, 13.4% have a moderate disability while 5.7% and 2.6% respectively fall into the severe and profound categories.

These results would suggest that the OIDS detection rate (proportion of all intellectually disabled on the OIDS client lists) is in the order of:

■ Mild	8%
■ Moderate	75%
■ Severe	67%
■ Profound	85%

If pre-school age children are ignored, and Education Department clients are allowed for, the detection rate by OIDS and the Education Department for persons over 5 years old is probably in the order of:

■ Mild	20%
■ Moderate	90%
■ Severe	97%
■ Profound	99%

The estimated True Prevalence Rate of 0.97% is considerably higher than other general estimates have been in Australia. It has to be asked whether in fact the figure of 0.97% is too high. Variations in a number of the key assumptions such as mortality and the detection rate at the severe and profound level aged 6 and above will in fact only produce relatively small variations in the final True Prevalence.

Only two assumptions can really significantly affect the final result. The first of these is the base ratios of Mild to Moderate to Severe/Profound for school age persons. The only way to really effectively ascertain whether the assumed ratios are reasonable is to repeat the data collection process carried out by Krupinski in the early seventies by collecting data on the Education Department clients with intellectual disabilities.

The second assumption is the estimate of the true prevalence rate for school children aged 6 to 16 years. In this paper it has been assumed the the ascertained prevalence of 0.71% represents an 80% detection rate therefore the true prevalence rate is 0.89% for that age group.

For the purposes of demonstrating the sensitivity of the estimate to these two assumptions, Table 4.8 was produced with the following assumptions:

- the true prevalence rate for 6 to 16 year olds is 0.95% given that the ascertained prevalence rate of 0.71% is assumed to represent 75% of the true prevalence rate.
- the ratio of persons aged 17–20 with a moderate intellectual disability to those with a severe or profound intellectual disability is raised from the 1.7 assumed for Table 4.7 to 2.0.

As can be seen, the main results are a slightly higher true prevalence rate of 1.03% and a lower detection rate for persons with a moderate intellectual disability.

A further assumption that has been implicitly made in the estimates is that persons do not shift categories over time. There is some evidence that this does in fact occur. Hence, the estimates of True Prevalence may be a little high in later age groups, especially in the case of persons in the mild category.

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1 Cocks, E., NG, P. Characteristics of Registered Clients of Mental Retardation Division. Mental Retardation Division of Health Commission of Victoria. Vol. 2, No. 2, June 1983.

2 World Health Organisation International Classification of Impairments, Disabilities and Handicaps. (Geneva 1980).

3 A New Pattern of Services for Intellectually Handicapped People in South Australia. Vol. 3. Related Working Papers Final Report of Intellectually Retarded Persons Project.

5. PROFILE OF ADULT DAY TRAINING CENTRE POPULATION

This section presents the functional profile of people attending Adult Day Training Centres during March–May 1988, which was collected in the same manner as data presented in Section 2.

5.1 STATEMENT OF PURPOSE

The purpose of this exercise was to develop a profile of the Adult Day Training Centre (ADTC) population which reflected client competencies in activities of daily life together with client needs related to any secondary disabilities experienced by people attending ADTC's so that recommendations could be based upon actual consumer service requirements.

5.2 METHODOLOGY

5.2.1 Population and Settings

The study population comprised all people with intellectual disabilities over the age of 18 years attending the 68 ADTC's in Victoria during the period March–May 1988.

All people in this category were registered clients of CSV/OIDs and were deemed to have an intellectual disability as defined by the **Intellectually Disabled Persons' Services Act, 1986.**

Raw data was collected at the individual Centres, which were located in every Region in Victoria.

5.2.2 Measurement Instrument

The **Client Profile Instrument** (appendix 1) used to develop the profile of the Residential Training Centre population was also used in this study. (see section 2.2.2 for a full description).

5.2.3 Data Collection and Analysis Procedures

Individual Client Profile Checklists for each ADTC Client were filled out by the Director of each Centre. In some cases, other staff and families assisted the Director. All ADTC's were visited by a member of the project team during the course of the study and procedures for training Directors and data analysis are described in Section 2.2.3.

5.3 RESULTS

5.3.1 Location of ADTC's and Response Rates

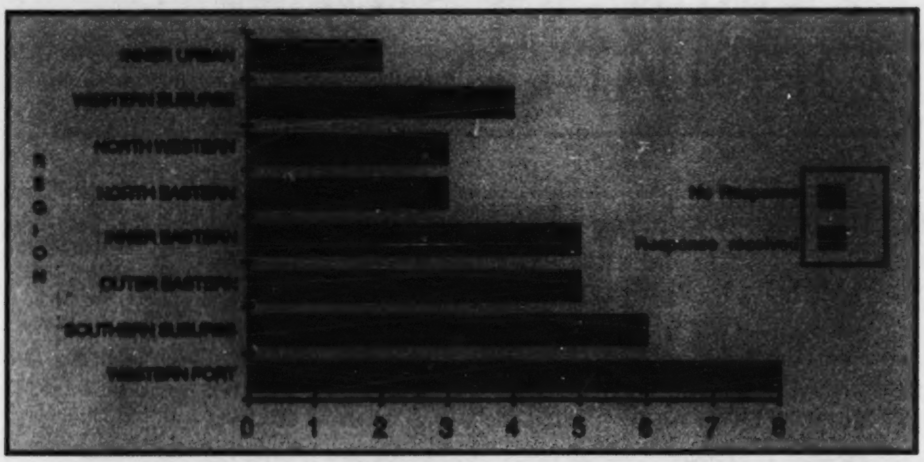

Figure 5.1: LOCATION AND RESPONSE RATE OF ADTC's SURVEYED IN METROPOLITAN REGIONS

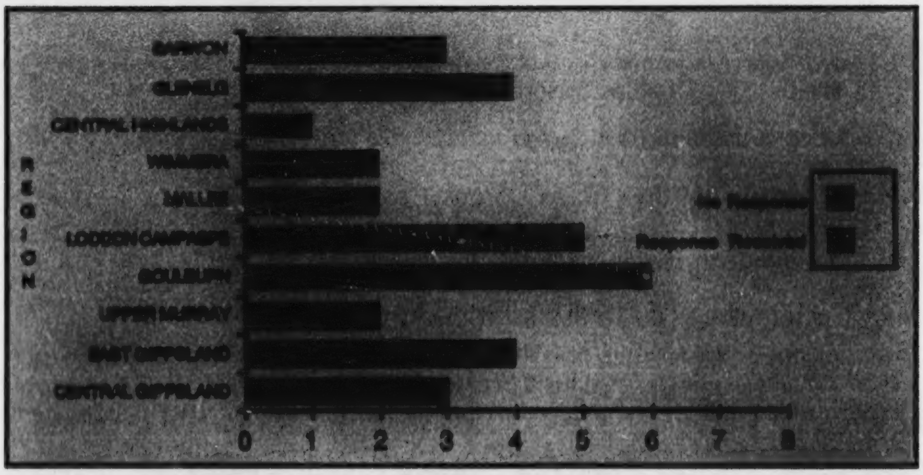

Figure 5.2: LOCATION AND RESPONSE RATE OF ADTC's SURVEYED IN COUNTRY REGIONS

All 68 Adult Day Training Centres, 36 in the Metropolitan area and 32 in the rural regions, were surveyed during the course of this exercise. As displayed in figures 5.1 and 5.2, 56 or 82% returned profiles on clients attending their Centres.

Data presented is therefore based on information received from 82% of ADTC's in Victoria.

5.3.2 Statewide Profile of ADTC Client Population

- **Number and Gender**

Our data indicates that there were 2,202 people with intellectual disabilities attending the 56 Adult Day Training Centres who took part in this study. Of these 52% (N = 1143) were men and 48% (N = 1059) were women.

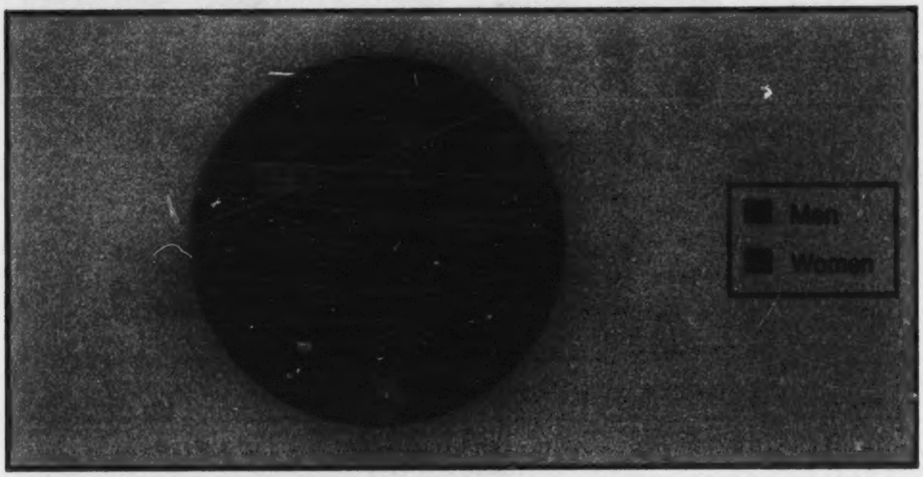

Figure 5.3: GENDER OF ADTC CLIENTS

- **Age Range**

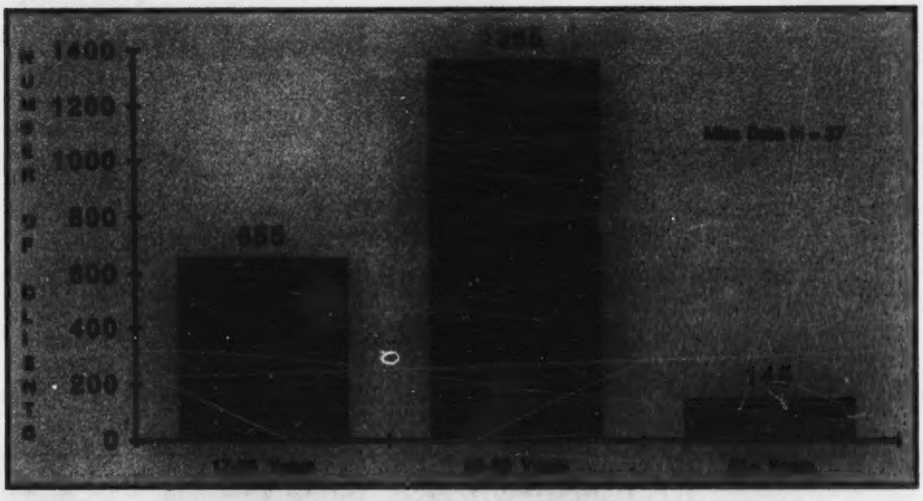

Figure 5.4: AGE RANGE OF PEOPLE ATTENDING ADTC's IN VICTORIA CORRECTED TO NOVEMBER 1988

As shown in figure 5.4, 30% were aged between 17 and 25 years, 62% were between 26 and 50 years of age and 7% were over 51 years. Data relating to 37 clients was not made available to us.

■ Living Arrangements

As displayed in Figure 5.5, 60% of ADTC clients attending the participating Centres lived with their families, 30% lived in supported accommodation, which included group homes, special accommodation houses and institutions and 4% lived independently. No information was provided to us for 6% of clients.

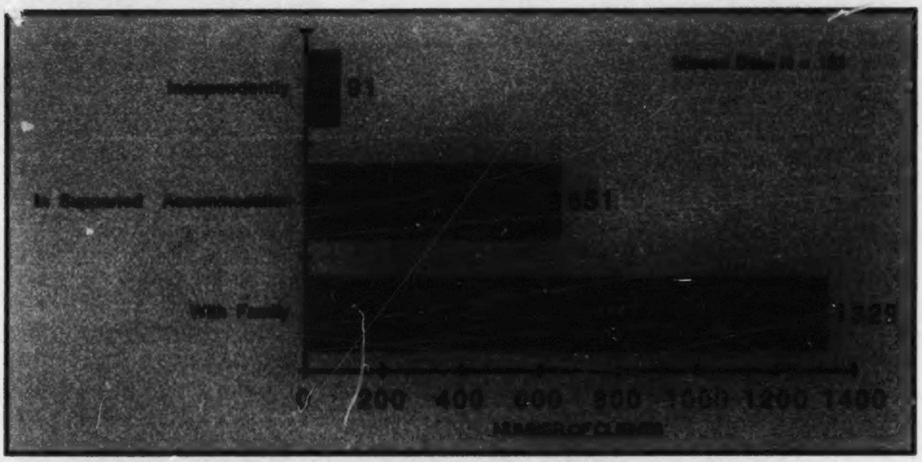

Figure 5.5: REPORTED LIVING ARRANGEMENTS OF PEOPLE ATTENDING ADTC's IN VICTORIA

■ Secondary Disabilities

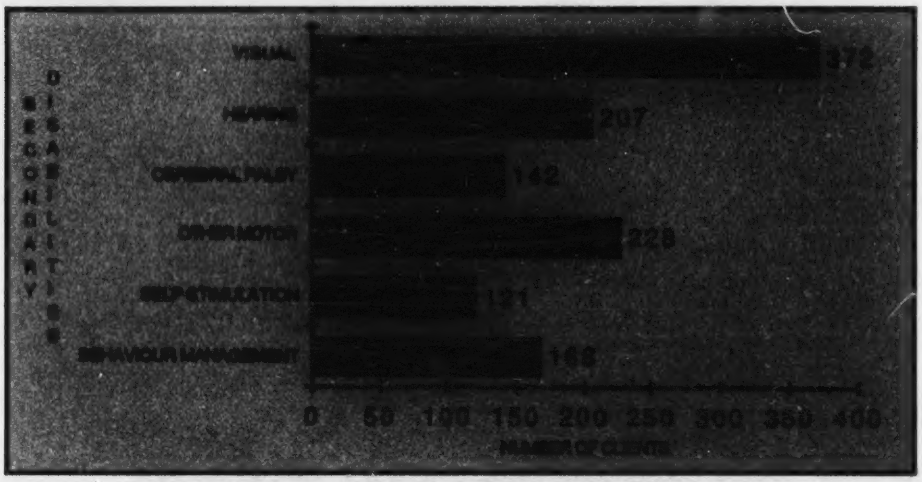

Figure 5.6: SECONDARY DISABILITIES EXPERIENCED BY ADTC CLIENTS

The reported extent of secondary disabilities experienced by people attending ADTC's is summarized in figure 5.6. This indicates that the most common secondary disability was a visual one (17% of clients). 9% had a hearing disability, 6% had cerebral palsy and 10% had some other motor disability. It was reported that 8% of the population required a behaviour management programme for undesirable social behaviours and that 5% exhibited repetitive self stimulatory/self abusive behaviour patterns.

- **Multiple Disabilities**

Data supplied to us indicates that few ADTC clients had multiple disabilities.

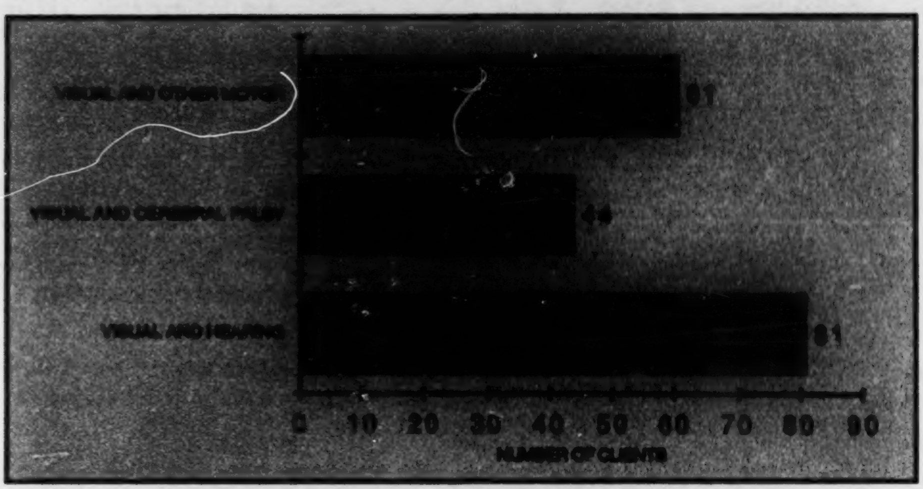

Figure 5.7: NUMBER OF PEOPLE ATTENDING ADTC's WHO HAD MULTIPLE DISABILITIES

- **Medical Conditions**

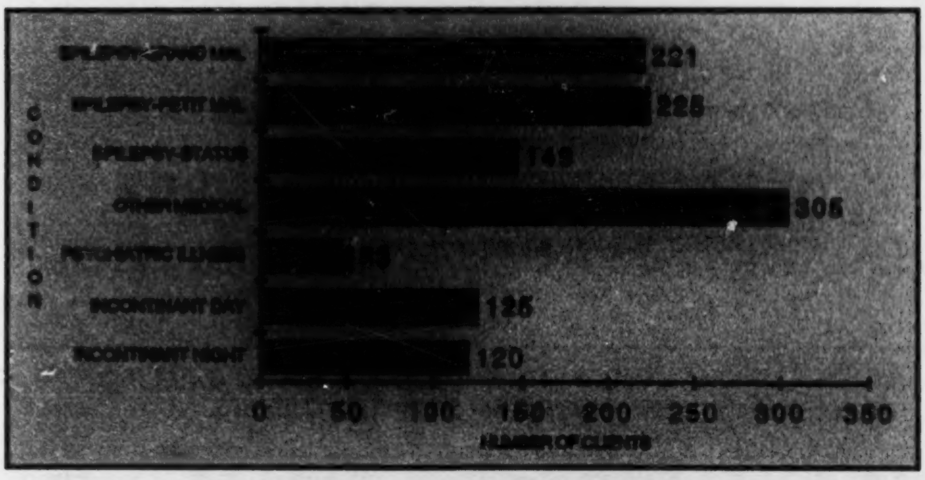

Figure 5.8: MEDICAL CONDITIONS EXPERIENCED BY ADTC CLIENTS

As shown in figure 5.8, the most prevalent reported medical condition was epilepsy. 10% of clients had petit mal seizures and 10% had grand mal seizures.

▪ Skill Strengths in Activities of Ordinary Daily Life

Our analysis of the levels of critical community living skills **actually performed by ADTC clients on a regular basis** in the course of their daily lives is presented in figures 5.9, 5.10 and 5.11.

This data, which was measured by our adaption of the Mid-Nebraska Community Living Skills Screening Test, presents the total number of clients who were independent in each of the ten behavioural domains at the three levels of independence shown in Table 2.1.

An examination of figure 5.9 which summarizes basic skills, indicates that the greatest number of clients (76% of the total ADTC population) ate their food without assistance and dressed themselves (68%). The smallest number regularly engaged in cleaning skills without assistance (20%).

Figure 5.10 summarizes independence in those skills required for semi-independent living and indicates that the greatest number of clients used an expressive language system efficiently (74%). The lowest number of clients prepared meals without assistance (6%).

Figure 5.11 shows the number of ADTC client who reportedly performed those skills required for an independent lifestyle on a regular basis. 53% were competent in interpersonal relations and only 4% planned meals and shopped without assistance.

When interpreting this data it is important to realize that it does not address the capabilities of ADTC clients; it indicates what they did at the time of data collection.

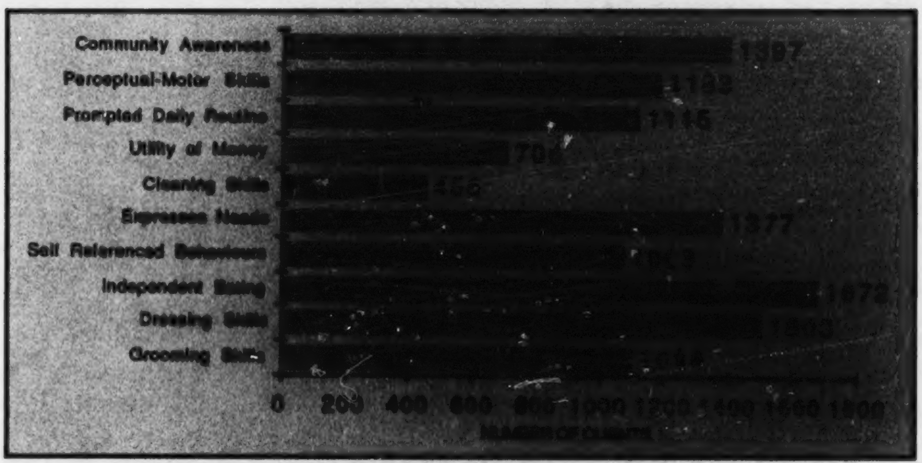

Figure 5.9: LEVEL 1: INDEPENDENCE IN THE BASIC SKILLS OF ORDINARY DAILY LIFE EXHIBITED BY ADTC CLIENTS

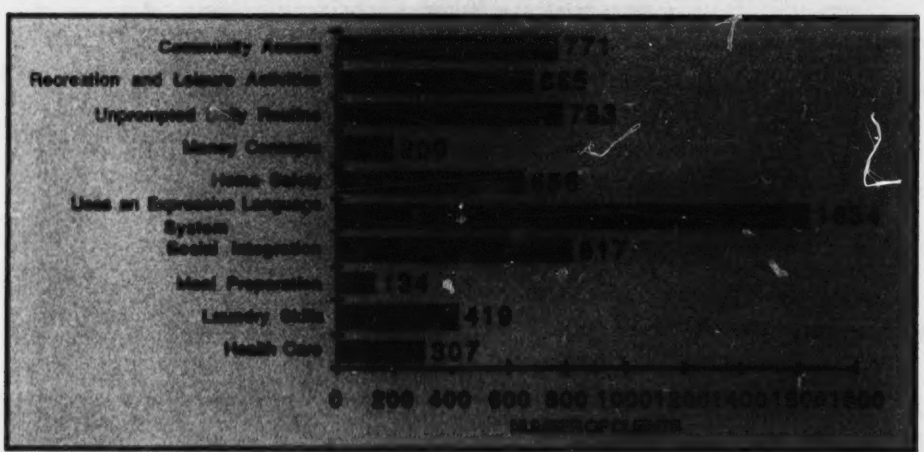

Figure 5.10: LEVEL 2: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR SEMI-INDEPENDENT COMMUNITY LIFE

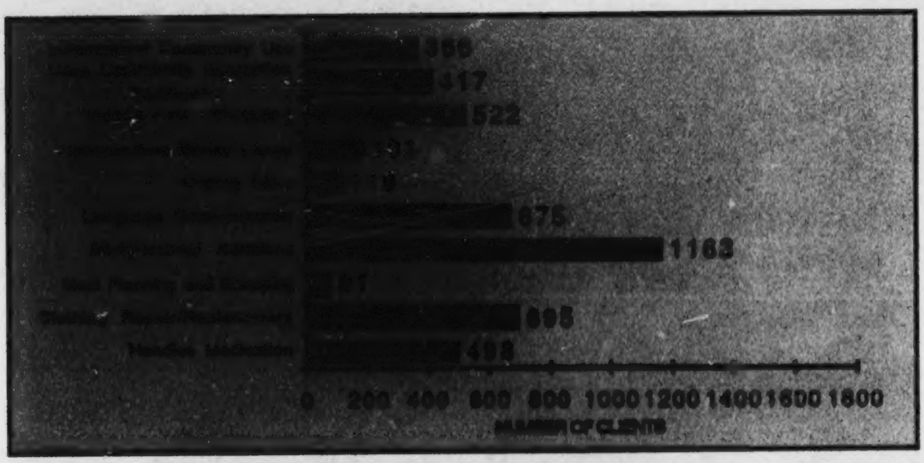

Figure 5.11: LEVEL 3: INDEPENDENCE IN COMMUNITY LIVING SKILLS REQUIRED FOR INDEPENDENT COMMUNITY LIFE

6. OVERVIEW OF ADULT DAY TRAINING CENTRES SERVICES

As we progressed with the preparation of the Ten Year Plan Project, it became evident that Adult Day Training Centres (ADTC's) obviously provided a significant service to many Victorians with intellectual disabilities. However, we were unable to gain a clear picture as to the scope of this service or an overview of the programmes Centres actually offered.

In order to gain this information a questionnaire was developed by Project Team members seconded from ADTC's and distributed to all 68 Centres in Victoria in March 1988. A total of 58 were returned, analysed and information gained used in the Project.

This section presents the findings of this aspect of the Project together with a description of the process undertaken.

6.1 THE PURPOSE

Our primary purpose in conducting this exercise was to gain information on a statewide basis relating to the types of programmes ADTC's offered to people with intellectual disabilities and the resources used in delivering those services.

6.2 METHOD USED

6.2.1 Measurement Instrument

A questionnaire format was used for the data-collection instrument which was designed to collect the information across the three discrete areas displayed in Table 6.1.

Table 6.1: SCOPE OF ADTC QUESTIONNAIRE

1. Client Variables	2. Programme Variables	3. Resource Variables
Population Characteristics Enrolment Procedures Programme Allocation	Types of Programmes Programme Components	Staff Numbers & Types Programme Allocation Transport Funding Committees of Management

Decisions to include items in the questionnaire were based on the type of information of interest to the Consultants and the seconded Team members' knowledge of the service system.

A first draft of the questionnaire was trialled at a metropolitan ADTC with both the Director and Administrator of that Centre providing feedback. Adjustments were then made to produce the final instrument.

6.2.2 Participants in Study

All ADTC's which operated day services exclusively for people with intellectual disabilities over the age of 18 years and whose major source of funding was through funding and service agreements with CSV/OIDS during March 1988 were surveyed. Multi-diagnostic services such as Sheltered Workshops were therefore excluded from the Study.

6.2.3 Procedures

Questionnaires, together with letters explaining the purpose of the data collection exercise were mailed to all 68 Centres. Back-up telephone contact for queries and comment was also offered. In addition, all Centres across the State were visited by at least one member of the Project Team during the course of the exercise.

Completed questionnaires were collated by the Project Team and analysed using the Excel Software package on the Apple MacIntosh System.

6.3 FINDINGS

6.3.1 Location of ADTC's Surveyed and Response Rate

All 68 Adult Day Training Centres, 36 in the Metropolitan area and 32 in Country Regions, were surveyed during the course of this exercise. As shown in the Regional breakdown in Figures 6.2 and 6.3 the number of Centres per Region varied considerably with eight located in Western Port Region and only one in the Central Highlands Region. (Mean = 4 per Region)

Of these 68 Centres, 58 or 85% responded to the questionnaire, with a 100% response rate from 11 of the 18 Regions. One ADTC in each of six Regions did not respond and four out of the eight Centres in Western Port (50%) declined to take part in the study (see Figures 6.2 and 6.3).

Data presented is therefore based on information received from 27 of the 32 Country ADTC's (84%) and 31 of the 36 Metropolitan ADTC's (86%). This distribution of non-responses should be taken into account when using information presented in this chapter.

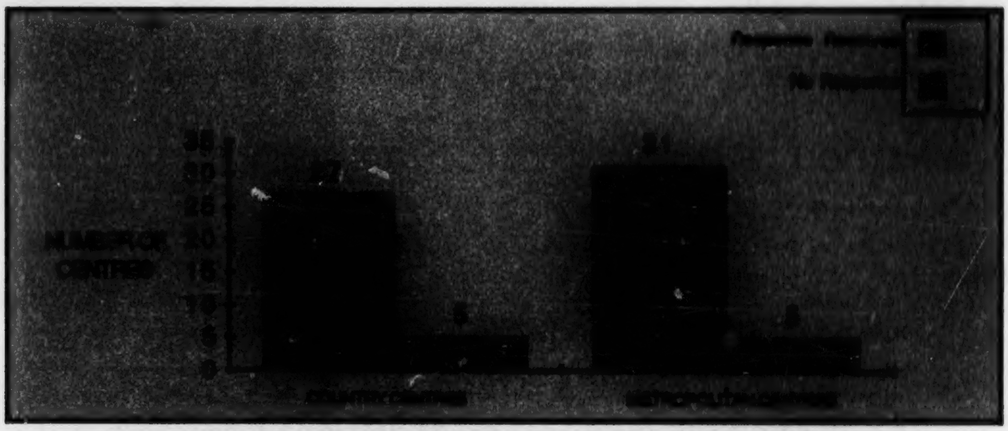

Figure 6.1: STATEWIDE RESPONSE RATE TO ADTC QUESTIONNAIRE

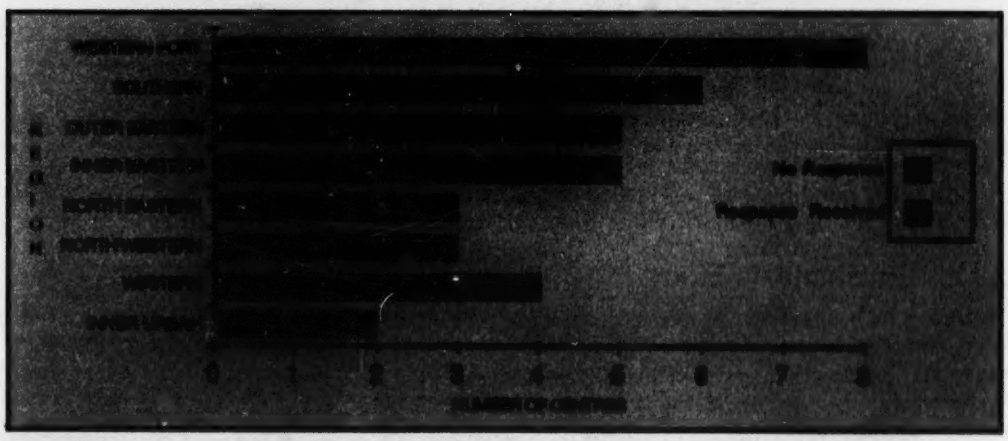

Figure 6.2: LOCATION AND RESPONSE RATE OF ADTC's SURVEYED IN METROPOLITAN REGIONS

Figure 6.3: LOCATION AND RESPONSE RATE OF ADTC's SURVEYED IN COUNTRY REGIONS

6.3.2 Characteristics of Adult Day Training Centre Clients

- **Numbers and Gender**

At the time of our data collection, (March–May, 1988) 2,388 adults with intellectual disabilities were enrolled in the programmes run by the 58 ADTC's who responded to the questionnaire. 950 people attended Country Centres and 1,438 attended those in the Metropolitan area (fig 6.4). Whereas a near equal number of men (N = 473) and women (N = 477) attended Country Centres, men (N = 770) reportedly outnumbered women (N = 668) in Metropolitan Centres. (figure 6.5)

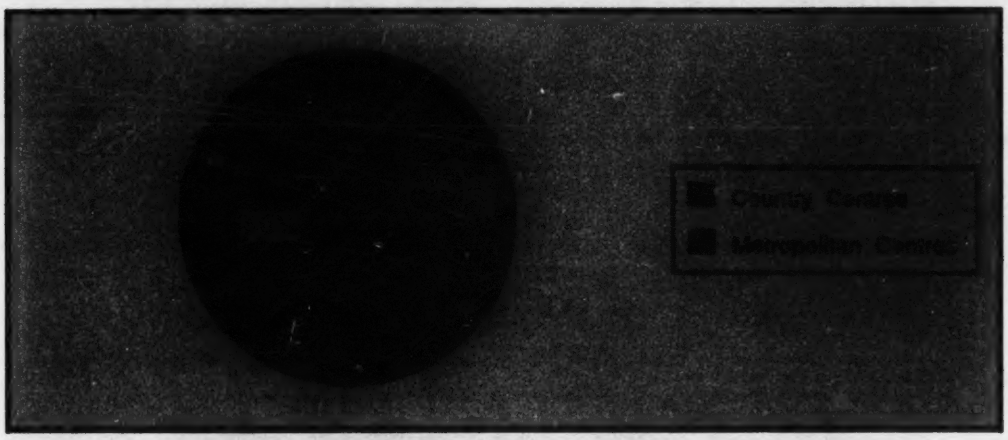

Figure 6.4: STATEWIDE DISTRIBUTION OF CLIENTS ATTENDING ADULT DAY TRAINING CENTRES

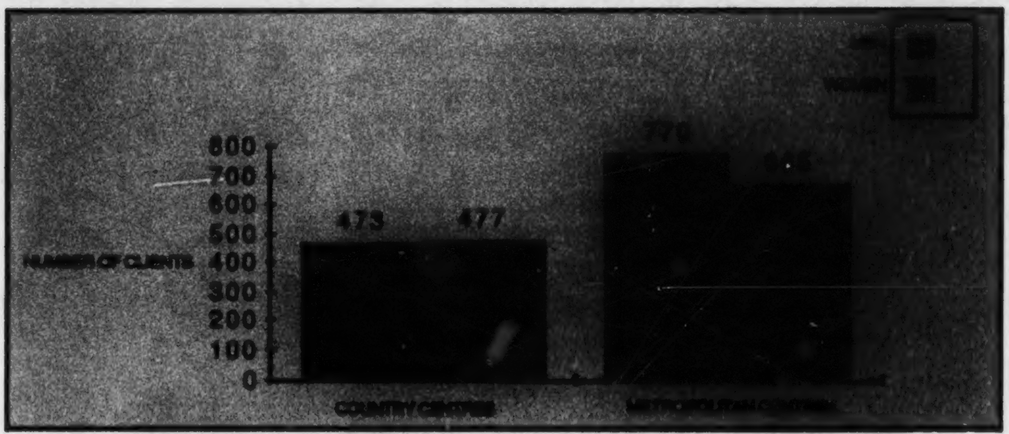

Figure 6.5: GENDER OF PEOPLE ATTENDING ADULT DAY TRAINING CENTRES ACROSS VICTORIA

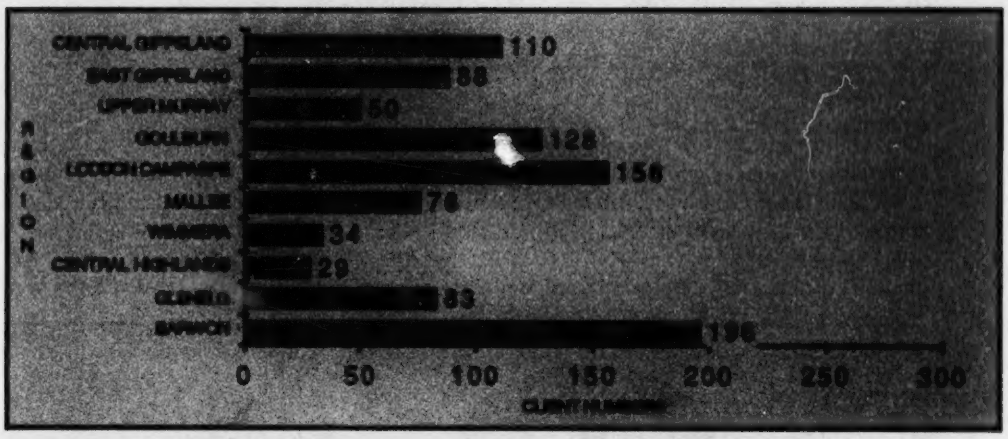

Figure 6.6: PEOPLE WITH INTELLECTUAL DISABILITIES ENROLLED IN ADTC's IN THE COUNTRY

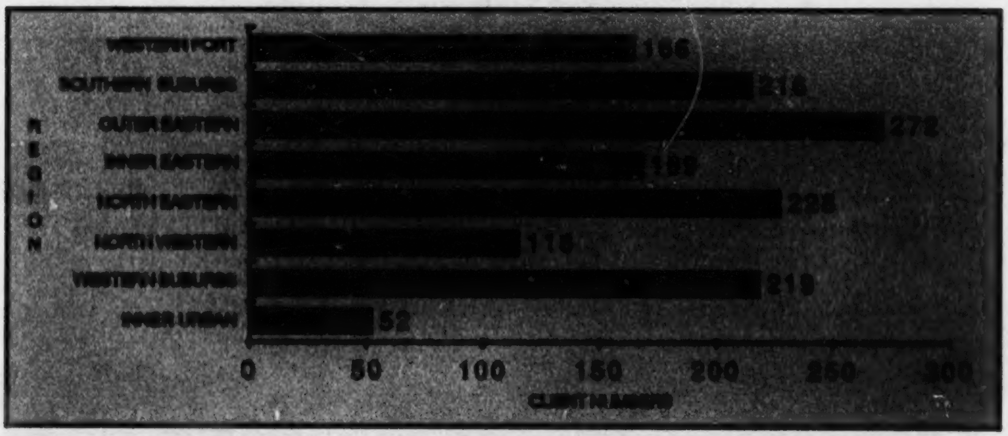

Figure 6.7: PEOPLE WITH INTELLECTUAL DISABILITIES ENROLLED IN ADTC's IN THE METROPOLITAN AREA

The number of people attending ADTC's in each Region is displayed in Figures 6.6 and 6.7. According to the data provided to us, the Outer Eastern Suburbs Region had the largest number (19%) of people enrolled in the metropolitan area and Inner Urban Region has the lowest enrolment (4%). The average number of ADTC clients per metropolitan region was 119.

In Country Regions, 20% of ADTC clients attend Centres in the Barwon Region and only 3% were enrolled in the Central Highlands. The average number of ADTC clients per Country Region was 95.

- **Enrolment Status of ADTC Clients**

Statewide, 90% (N = 2,155) of all people enrolled in ADTC's attend on a full time basis. Of the 233 part-timers, approximately twice as many attend Country Centres (N = 153) as Metropolitan Centres (N = 80). (See Figure 6.9) The Regional breakdown of this data is shown in Figure 6.10 and 6.11. This indicates that both the Loddon Campaspe and Goulbourn Regions had a considerably higher proportion of part-timers than other Regions.

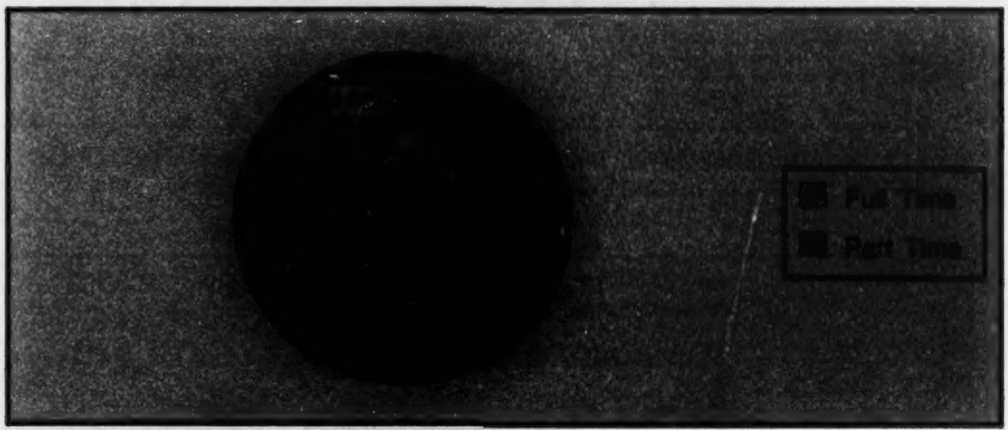

Figure 6.8: STATEWIDE ENROLMENT STATUS OF PEOPLE WITH INTELLECTUAL DISABILITIES ATTENDING ADTC's

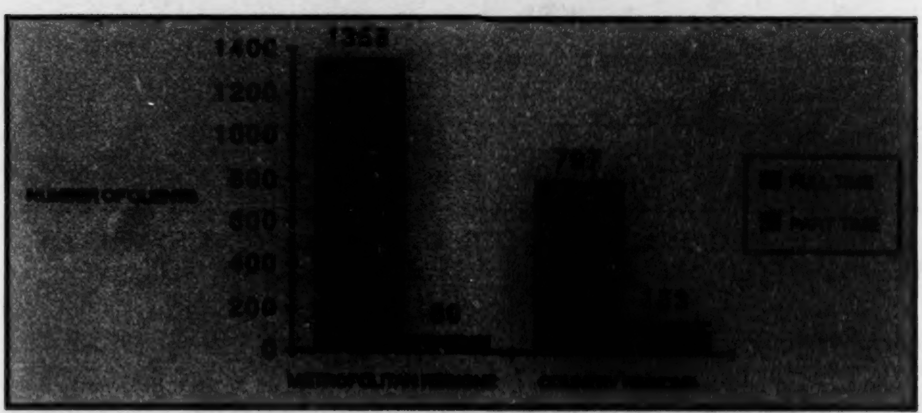

Figure 6.9: COMPARISON OF ENROLMENT STATUS BETWEEN CLIENT ENROLMENTS IN METROPOLITAN AND COUNTRY REGIONS

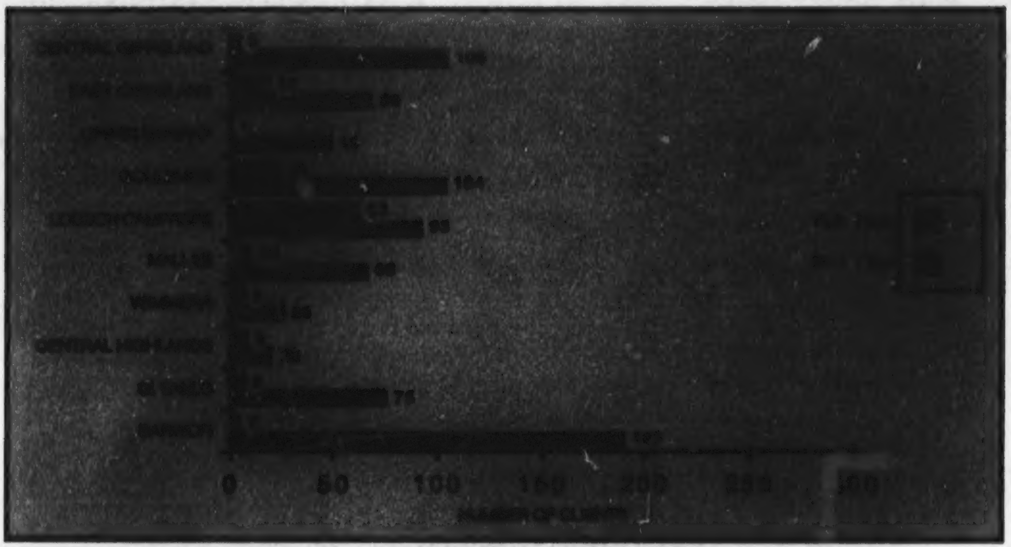

Figure 6.10: REGIONAL BREAKDOWN OF ENROLMENT STATUS OF PEOPLE ATTENDING COUNTRY ADULT DAY CENTRES

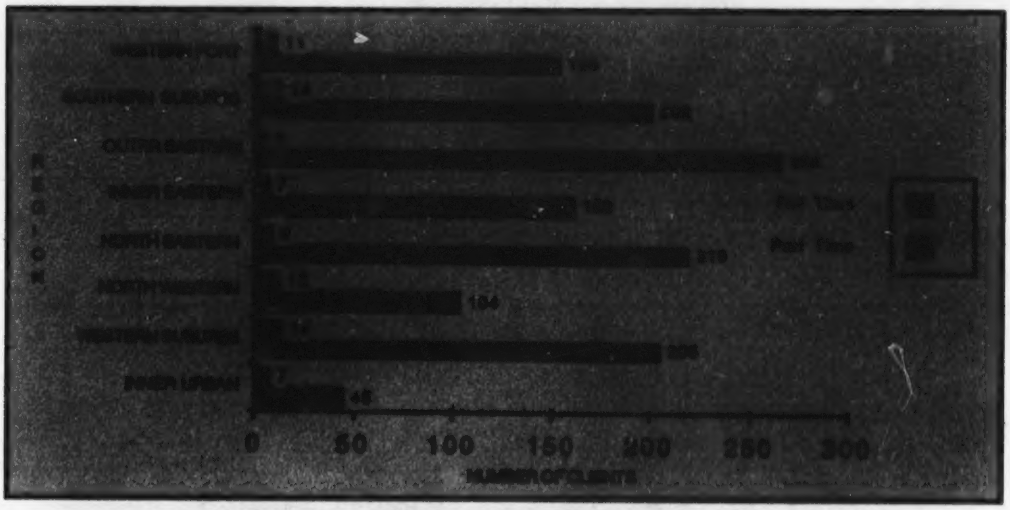

Figure 6.11: REGIONAL BREAKDOWN OF ENROLMENT STATUS OF PEOPLE ATTENDING ADTC's IN THE METROPOLITAN AREA

- **Age Range**

Figure 6.12 indicates that 49% (N = 1159) of all ADTC clients were aged between 26 and 40 years, 30% (N = 705) were in the 17–25 age bracket, 19% (N = 457) were mature adults and only 43 or 2% had reportedly reached retirement age. Data relating to client-age from one Centre in the Loddon/Campaspe Region which had 24 people enrolled, was not made available to us.

Whereas this overall pattern was similar across both Country and Metropolitan Regions, according to our data people attending ADTCs in the Metropolitan area were younger than those attending Country Centres. As can be seen in Figure 6.13 & 6.14, 81% of Metropolitan clients were under the age of 40 years compared with 74% of those attending Country Centres.

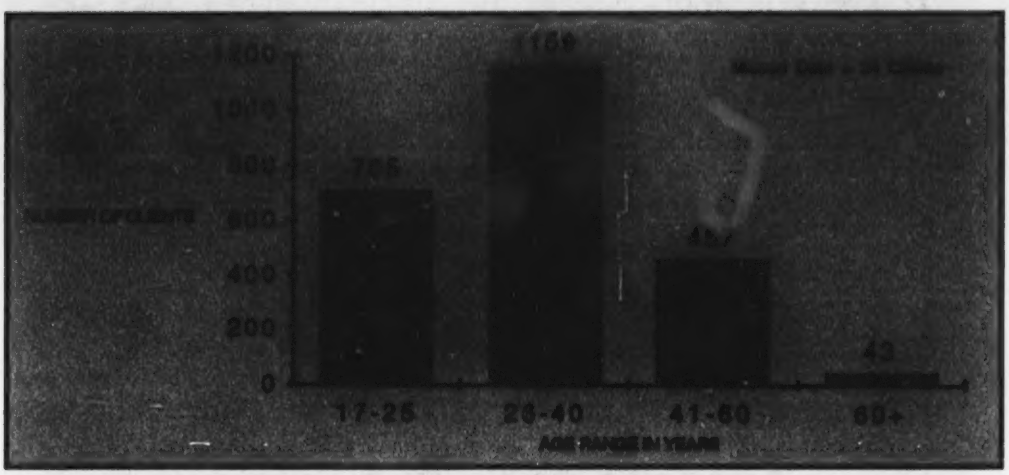

Figure 6.12: AGE RANGE OF PEOPLE WITH INTELLECTUAL DISABILITIES ATTENDING ADTC's IN VICTORIA

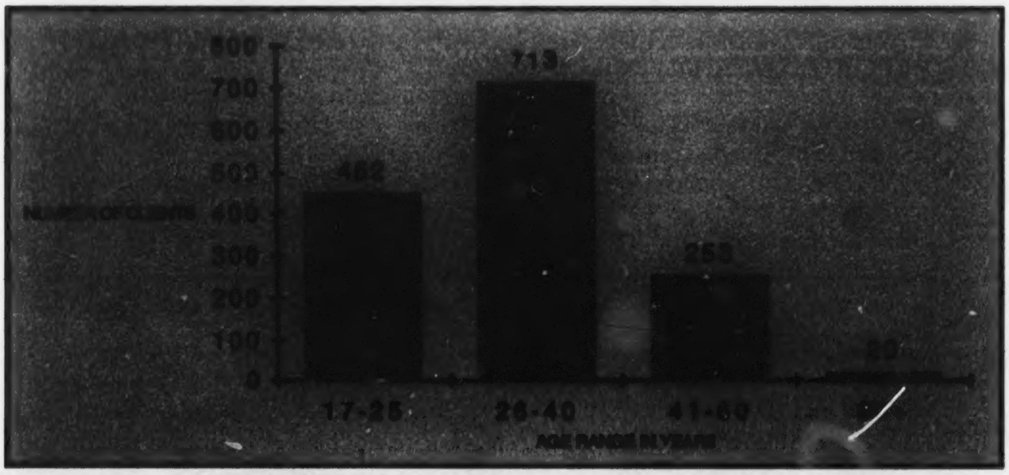

Figure 6.13: AGE RANGE OF PEOPLE WITH INTELLECTUAL DISABILITIES ATTENDING METROPOLITAN ADTC's

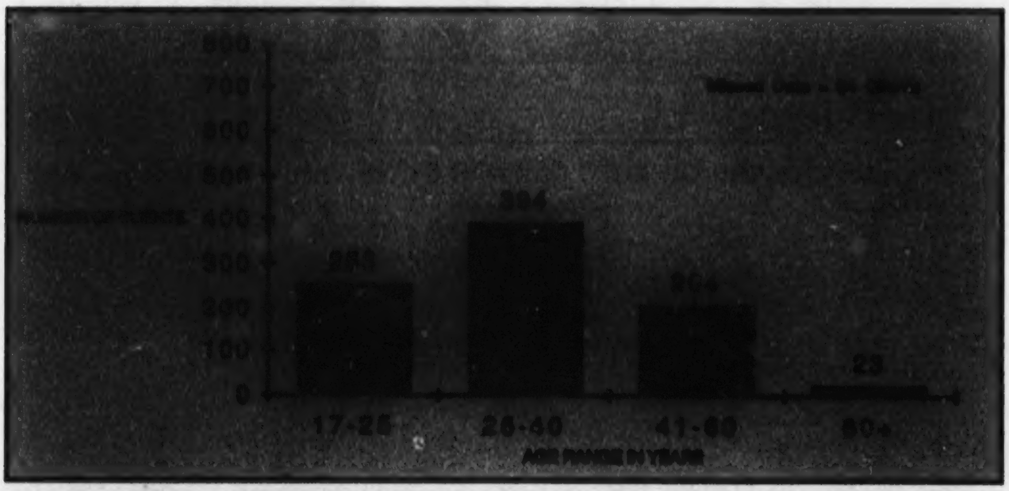

Figure 6.14: AGE RANGE OF PEOPLE WITH INTELLECTUAL DISABILITIES ATTENDING COUNTRY ADTC's

▪ Clients with no verbal skills

As shown in figure 6.15, only 406 people or 17% of all people attending ADTC's across the State, had no reported verbal skills. According to our data this was consistent across both Country (N = 153 = 16%) and Metropolitan (N = 253 = 18%) areas.

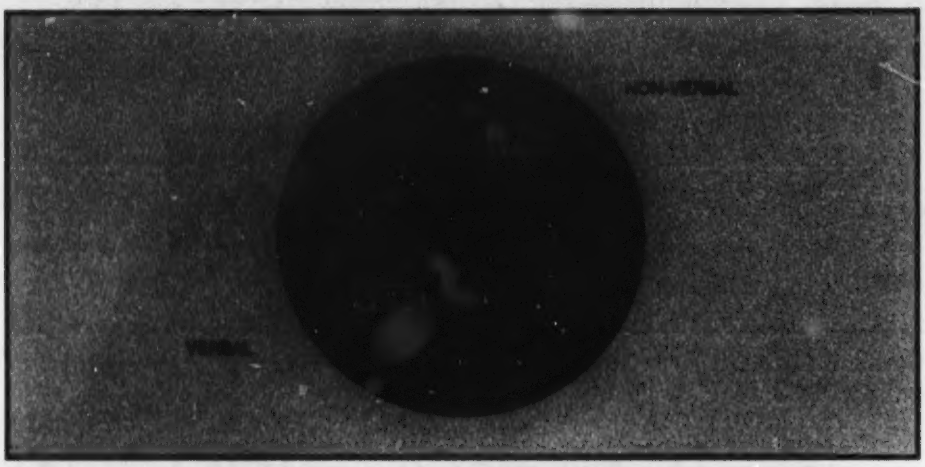

Figure 6.15: NUMBER OF ADTC CLIENTS STATEWIDE WITH NO REPORTED VERBAL SKILLS

When these figures are analysed according to age, our data indicates that a greater proportion of younger ADTC Clients were non-verbal (see Figure 6.16). Of all people attending Centres who were under 26 years at the time of the data collection, 26% had no verbal skills. This is reasonably consistent across the State, with 3 percentage points difference being reported between Country and Metropolitan areas (see Figure 6.17 and 6.18).

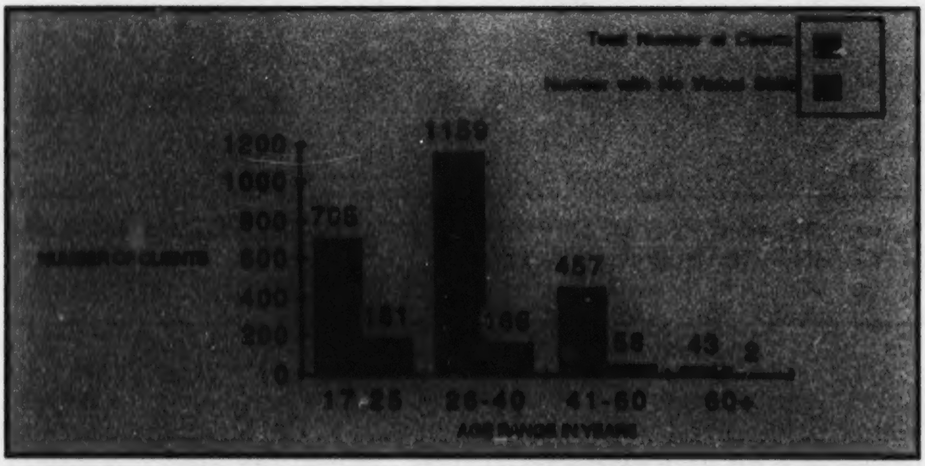

Figure 6.16: AGE OF ADTC CLIENTS STATEWIDE WITH NO VERBAL SKILLS

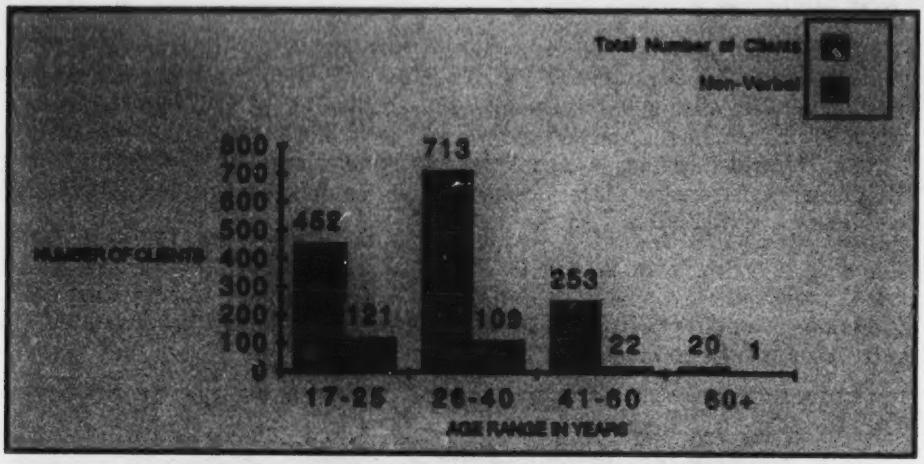

Figure 6.17: AGE OF CLIENTS WITH NO REPORTED VERBAL SKILLS ATTENDING ADTC's IN METROPOLITAN REGIONS

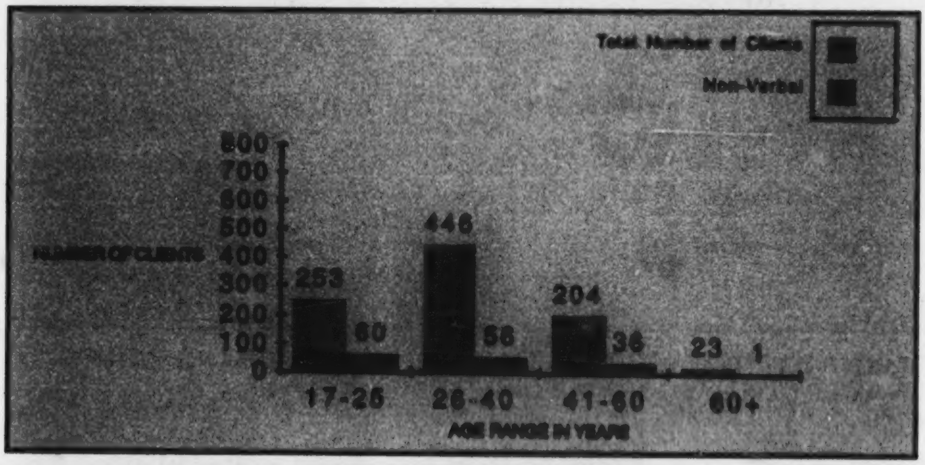

Figure 6.18: AGE OF CLIENTS WITH NO REPORTED VERBAL SKILLS ATTENDING ADTC's IN COUNTRY REGIONS

▪ Clients who are non-ambulant

Only 99 people, 44 attending Country Centres and 55 attending Metropolitan Centres, were unable to walk according to our data. As shown in Figure 6.19, 48% of these were under the age of 26 years.

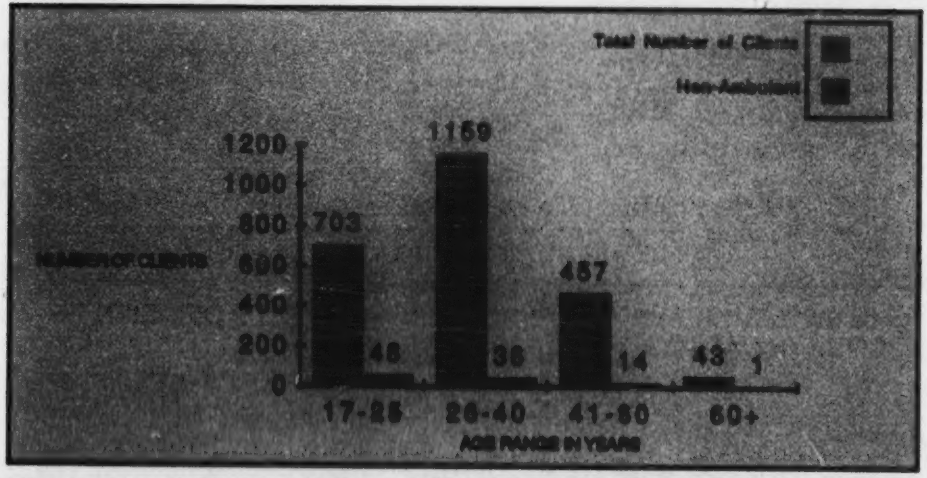

Figure 6.19: AGE OF NON-AMBULANT CLIENTS ATTENDING ADTC's

▪ Living Arrangements

As can be seen in Figure 6.20, our data indicates that most people who attend ADTC's in Victoria lived with their families (N = 1459). This is 63% of the total ADTC client population of the 55 Centres who supplied data relating to this variable. 15% of clients lived in Group Homes of one sort or another, 9% lived in hostel-type accommodation, including Special Accommodation Houses and 5% lived independently. Only 90 people from institutions attended ADTC's. This is 4% of the total ADTC client population. It was also reported that small numbers of people lived in Nursing Homes, Co-residency and home board arrangements.

An examination of data shown in Figures 6.21 and 6.22, revels that the above percentages are consistent across Country and Metropolitan Regions, except that slightly more Country Clients (17%) lived in group homes than did city dwellers (13%). More people in the city however lived in Hostels or Special Accommodation Homes (12% compared with 7%).

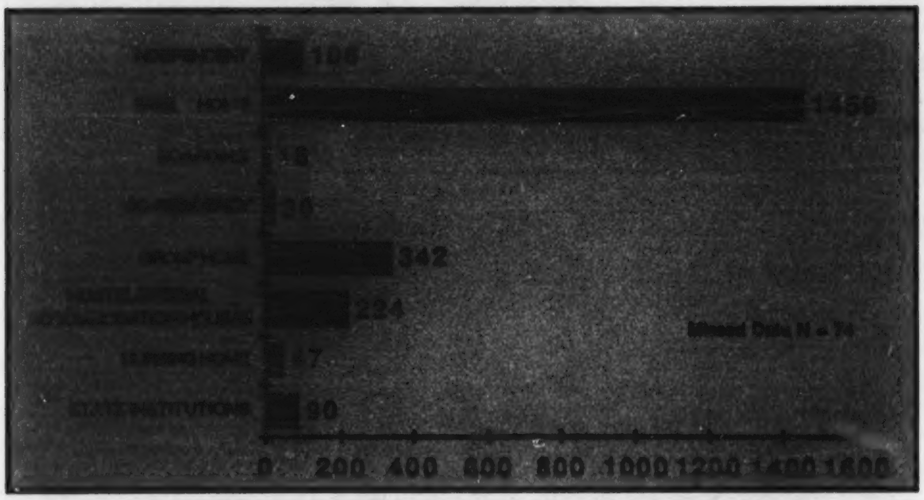

Figure 6.20: STATEWIDE SUMMARY OF LIVING ARRANGEMENTS OF ADTC CLIENTS

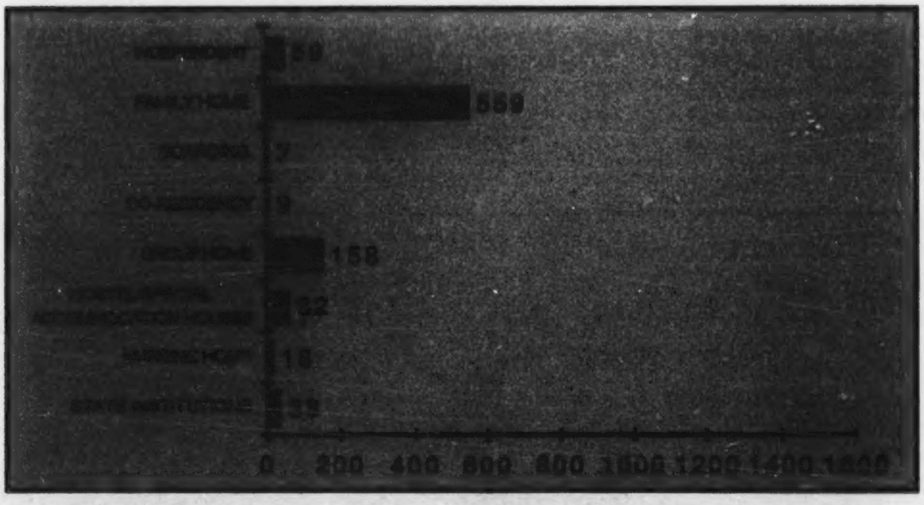

Figure 6.21: SUMMARY OF LIVING ARRANGEMENTS OF CLIENTS OF COUNTRY ADTC's

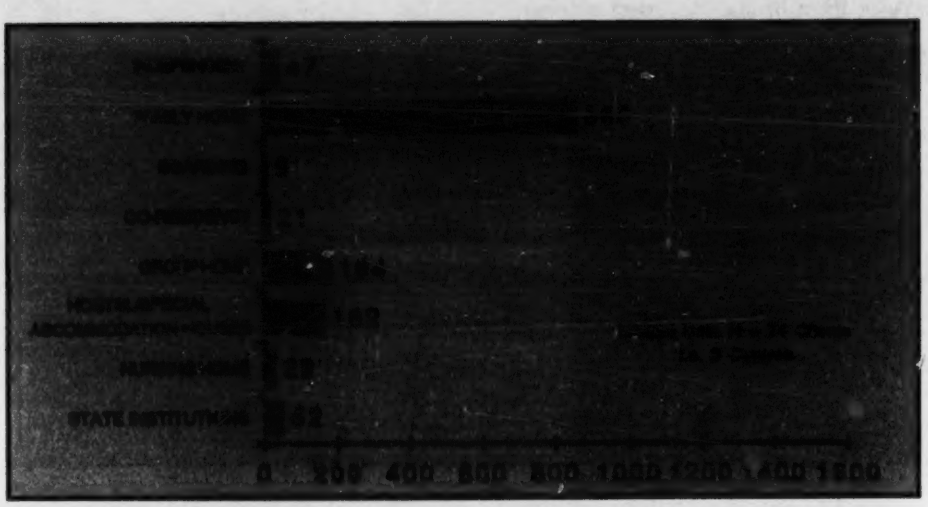

Figure 6.22: SUMMARY OF LIVING ARRANGEMENTS OF CLIENTS OF METROPOLITAN ADTC's

6.3.3 Staffing of Adult Day Training Centres

- **Staff Numbers and Types**

54 ADTC's, (25 Country and 29 Metropolitan Centres) supplied data relating to staff during the course of this exercise. This information is summarized in Table 6.2.

Table 6.2: SUMMARY OF ATDC STAFFING

Staffing Category	Country Staff		Metropolitan Staff		Statewide	
	No.	%	No.	%	No.	%
Direct Contact	180.1	52	279.7	63	459.8	59
Direct Specialist	6	2	12.9	3	18.9	2
Transport	57.93	17	69.6	16	127.5	16
Administration	33.96	10	42.23	10	[illegible]	10
Other	66.3	19	35.5	8	101.8	13
TOTAL ALL STAFF	344	100	440	100	786	100
Volunteers (over 12 month period)	217		265		482	
GRAND TOTAL	561		707		1268	

As shown, it was reported that the total of 786 staff were employed in these 55 ADTC's and that they were assisted by 482 volunteers over the course of a 12 month period.

Most staff (59%) were involved in the direct instruction of clients, with a higher proportion (63%) of Metropolitan Centre Staff being in this Category. The next most common category was that of Staff members involved in transporting clients to and from Centres (16%), with a slightly higher percentage in the Country. The percentage of administration staff (10%) was constant across the state.

According to these figures, very few specialists were available to clients at Centres, with only 18.9 people in this category being employed Statewide.

▪ Allocation of Staff to Programmes

As shown in Table 6.3, it was reported that most staff were allocated to programmes based upon their perceived expertise in a programme area, or were reportedly employed specifically for set programme areas.

Table 6.3: MATCHING DIRECT SERVICE STAFF TO PROGRAMMES

[illegible]	[illegible]	[illegible]	[illegible]
1. [illegible]	[illegible]	[illegible]	[illegible]
2. [illegible]	[illegible]	[illegible]	[illegible]
3. [illegible]	[illegible]	[illegible]	[illegible]
4. [illegible]	[illegible]	[illegible]	[illegible]

6.3.4 Programmes for Adult Day Training Centre Clients

▪ Overview and Emphasis

Figures 6.23, summarizes the programme areas offered by ADTC's to their clients. As can be seen the most widely available programmes in the ADTC's taking part in this survey were in the Socialization (91% of Centres) Independent Living (90% of Centres), Vocational (86% of Centres) and Pre-vocational (86% of Centres) programming areas.

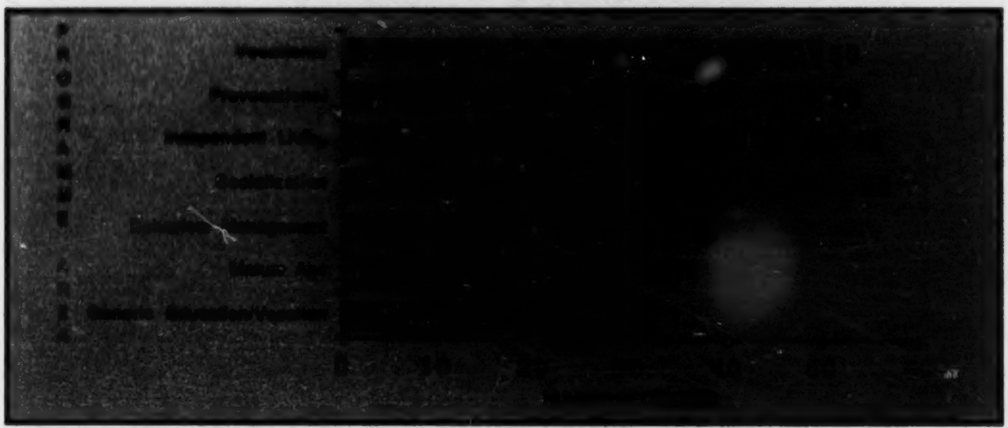

Figure 6.23: PROGRAMME AREAS OFFERED TO CLIENTS OF ADTC's IN VICTORIA

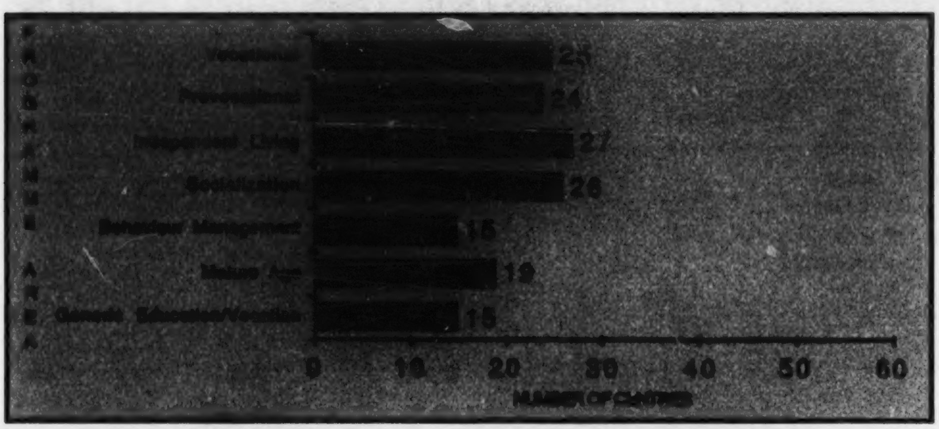

Figure 6.24: PROGRAMME AREAS OFFERED TO CLIENTS OF COUNTRY ADTC's

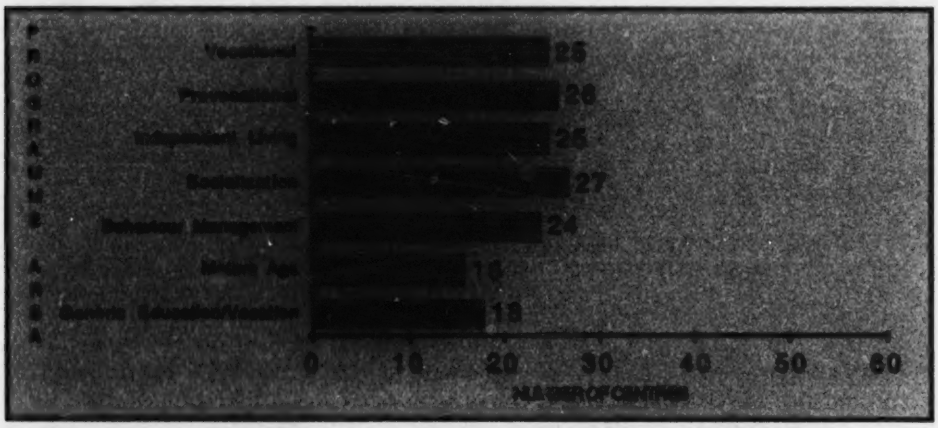

Figure 6.25: PROGRAMME AREAS OFFERED TO CLIENTS OF METROPOLITAN ADTC's

All Country Centres reported that they offered independent living programmes compared with 81% of Metropolitan Centres. Vocational, Pre-vocational and Socialization programmes were also offered at more Country Centres than Metropolitan Centres. However, a greater percentage of Metropolitan Centres offered Behaviour Management and access to generic education/vocational programmes (Figures 6.24 and 6.25).

The emphasis that Centres placed on each programme area is shown in Table 6.4. As can be seen, 72% of all ADTC's in the survey reported that Vocational programmes were given a high priority, this was considerably higher in rural Centres (89%) than in Metropolitan Centres (58%). Pre-vocational (71%) and Independent Living (74%) programmes also received a relatively high priority, statewide, but much more so in Country regions.

Table 6.4: REPORTED EMPHASIS ON PROGRAMME AREAS IN ADTC's

Programme Area	High Priority Country ADTC's		High Priority Metropolitan ADTC's		High Priority Statewide	
	No.	%	No.	%	No.	%
Vocational	24	89	18	58	42	72
Prevocational	21	78	20	64	41	71
Independent Living	22	81	21	68	43	74
Socialization	18	67	18	58	36	62
Behaviour Management	7	26	9	29	16	28
Mature Age	7	26	7	23	14	24
Generic Education/Vocation	9	33	8	26	17	29
Total Number in Survey	27	100	31	100	58	100

■ Vocational Programmes

It was reported that ten discrete programmes within the Vocational area were offered by ADTC's. These are displayed in Table 6.5. As can be seen, the programme most widely available was centre-based "basic work skills". Statewide, 74% of all Centres in the survey ran this programme with a higher proportion in the metropolitan area (77% of Centres) than rural regions (70% of Centres).

Other readily available programmes were Work Experience (66% of Centres) and Centre-based Sub-Contract work (62% of Centres). These were both more common in Country Centres (74% = work experience; 70% sub-contract) than Metropolitan Centres (58% work experience; 55% sub-contract).

Full-time Supported Employment was available at 29% of Centres; 23% Metropolitan and 37% Country; whereas access to part-time supported employment at 16% was consistent across the State. Open Employment was offered at more Metropolitan Centres (19%) than Country Centres (11%).

Enclaves offering paid employment were more readily available in Country Centres (44% of Centres) than Metropolitan ADTC's (32%) as was access to work crew type employment (70% Country compared with 45% Metropolitan).

Table 6.5: PROGRAMMES OFFERED TO ADTC CLIENTS IN VICTORIA

Discrete Programmes	Country Regions Centres		Metropolitan Regions Centres		Statewide Centres	
	No.	%	No.	%	No.	%
1. Basic Work Skills (Centre Based)	19	70	24	77	43	74
2. Sub-contract Work (Centre Based)	19	70	17	55	36	62
3. Work Experience	20	74	18	58	38	66
4. Enclave (non-paid)	5	18	4	13	9	16
5. Enclave (paid)	12	44	10	32	22	38
6. Work Crews (Community-based)	19	70	14	45	33	57
7. Supported Employment Part-time	4	15	5	16	9	16
8. Supported Employment Full Time	10	37	7	23	17	29
9. Supported Employment Casual	3	11	1	3	4	7
10. Open Employment	3	11	6	19	9	16
TOTAL NUMBER IN SURVEY	27	100	31	100	58	100

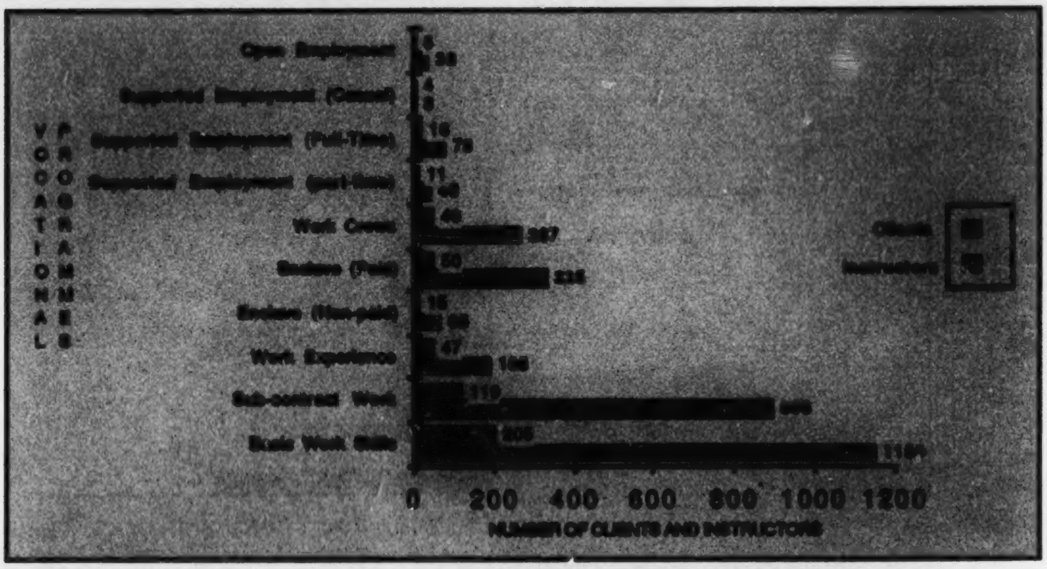

Figure 6.26(a): ADTC CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE VOCATIONAL PROGRAMMES IN VICTORIA

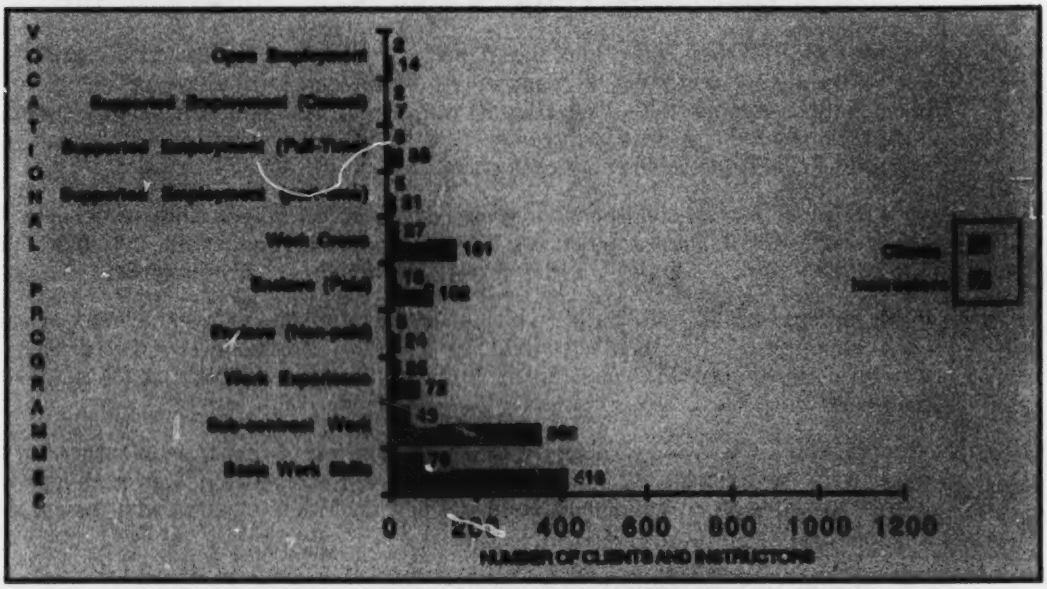

Figure 6.26(b): CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE VOCATIONAL PROGRAMMES IN COUNTRY ADTC's

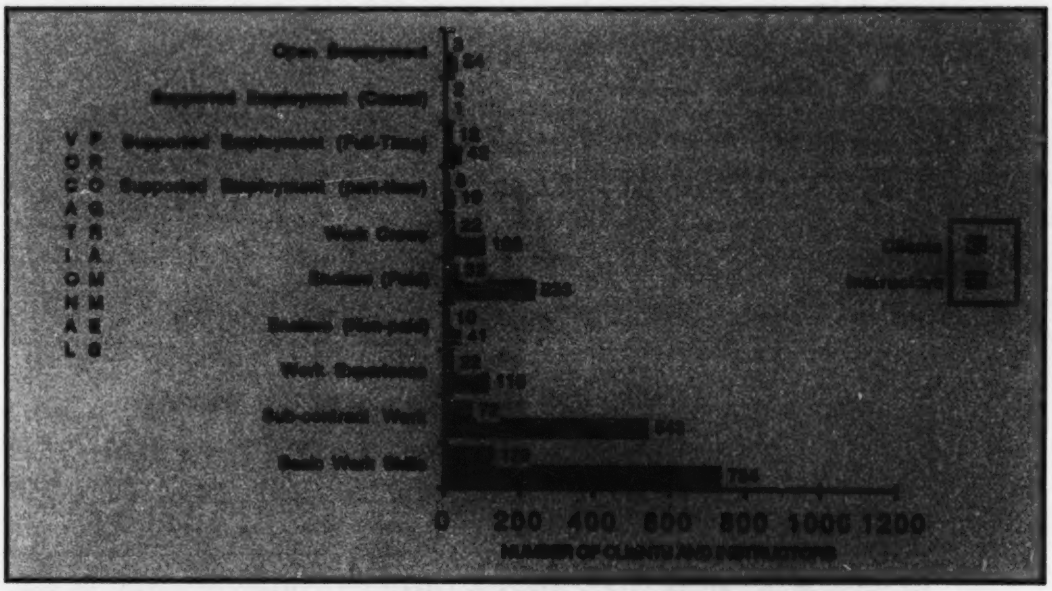

Figure 6.26(c): CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE VOCATIONAL PROGRAMMES IN METROPOLITAN ADTC's

Figures 6.26(a), 6.26(b) and 6.26(c) summarize the number of clients and instructors involved in each of the discrete vocational programmes. As can be seen, most instructors (48%) were engaged in teaching basic work skills or sub-contract work (26%), both of which were consistant across the State. Our data indicates that, at the time of data collection, very few instructors were engaged in supporting clients in employment or enclaves.

48% (N = 1150) of all clients attending the ADTC's contributing to this survey were involved in "basic work skills" training programmes; 51% in Metropolitan Centres and 43% in Country Centres. Sub-contract work at Centres was the next most common activity for clients (38% N = 896).

It was reported that very few people with intellectual disabilities were either in Open Employment (2%) or Supported Employment full time (3%) or part time (2%) and there was no difference between Country and Metropolitan Centres. Small numbers also attended Work experience (8%) or did non-paid work in enclaves (3%).

Work in Work Crews was available to a greater proportion of Country people (N = 161, 17%) than those in the Metropolitan area (N = 106, 7%) but paid enclave work was more readily provided for clients attending Metropolitan Centres (N = 233, 16%) compared with their Country peers (N = 102, 11%).

- **Pre-Vocational Programmes**

Training in ten discrete skills was reportedly offered in the Pre-Vocational Programme area and this is displayed in Table 6.6. Most Centres offered instruction in "Socially Appropriate Behaviour" (81%), "Taking Direction" (81%) "Ability to relate to Co-workers (78%), "Work Procedures and Routines" (78%), "Work role Identification" (76%), "Use of Equipment" (74%) and Self Discipline (74%) and this was reportedly reasonably consistent across the State, except that instruction in "Work Role Identification" was more common in Metropolitan Centres (81%) than Country Centres (70%) as was training in "Work Procedures" (84% compared with 70%) and "ability to relate to co-workers" (81% compared with 74%).

Only 28 ADTC's (48%) offered instruction in independent travel to and from the Centre, and this was much lower in the Country where only 33% of Centres offered this programme.

Table 6.6: PRE-VOCATIONAL PROGRAMMES

Personal Skill Area	Country Regional Centres		Metropolitan Regional Centres		Statewide Centres	
	No.	%	No.	%	No.	%
1. Self-Concepts	20	74	23	74	43	74
2. Work Area Identification	19	70	25	81	44	76
3. Work production/ Output	19	70	26	84	45	78
4. Use of Equipment	20	74	23	74	43	74
5. Time Management	17	63	21	68	38	66
6. Personal maintenance	19	70	21	68	40	69
7. Ability to relate to co-workers	20	74	25	81	45	78
8. Taking Direction	21	78	26	84	47	81
9. Independent Travel to Centre	9	33	19	61	28	48
10. Socially appropriate Behaviour	22	81	25	81	47	81
TOTAL NUMBER IN PROGRAM	27	100	31	100	58	100

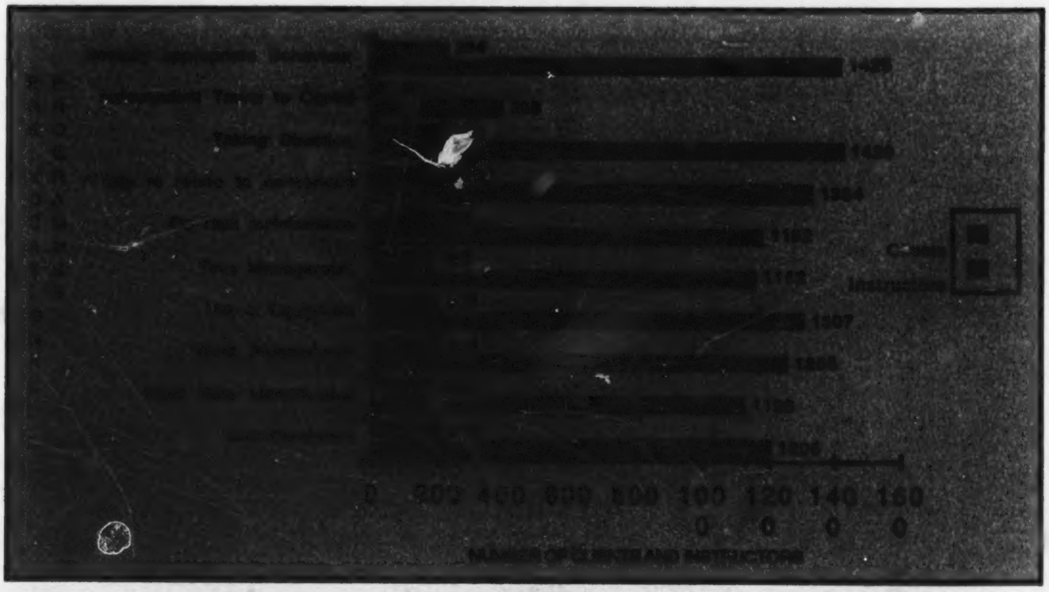

Figure 6.27(a): CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE PRE-VOCATIONAL PROGRAMMES IN ADTC's IN VICTORIA

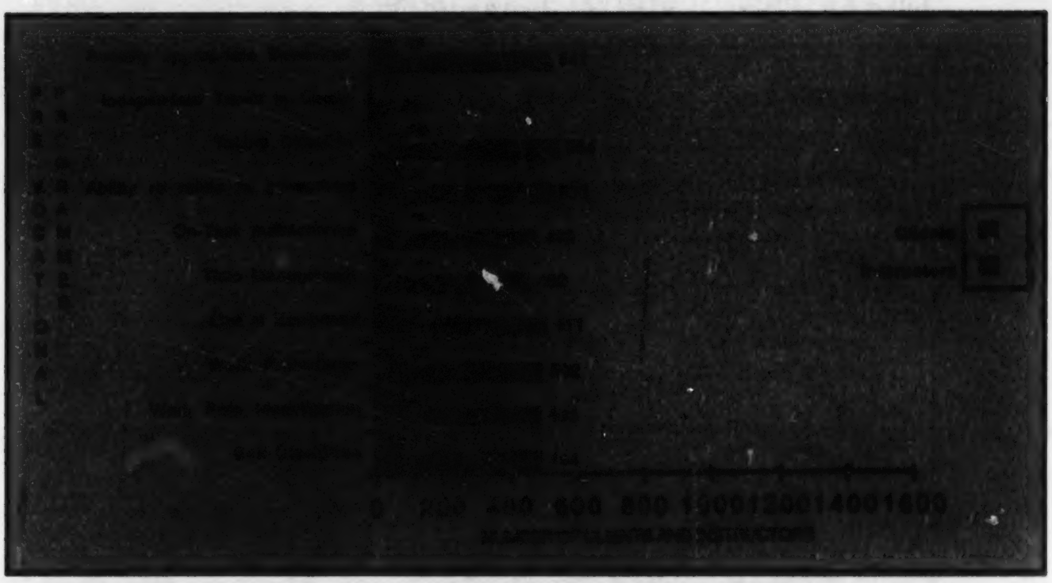

Figure 6.27(b): CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE PRE-VOCATIONAL PROGRAMMES IN COUNTRY ADTC's

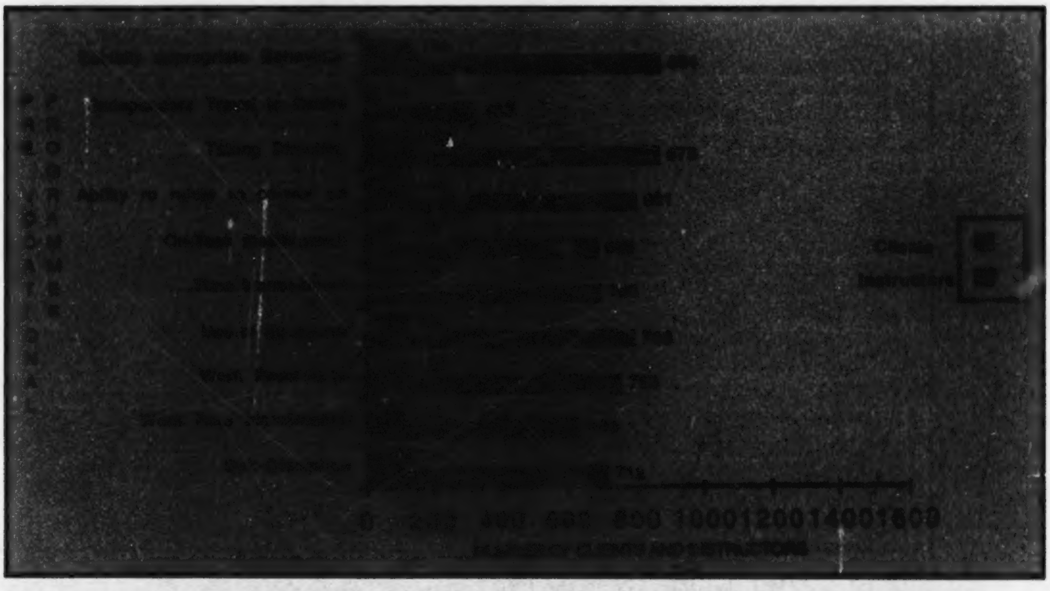

Figure 6.27(c): CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE PRE-VOCATIONAL PROGRAMMES IN METROPOLITAN ADTC's

As seen in figures 6.27(a), 6.27(b) and 6.27(c), 60% of clients received instruction in "Taking Direction" and "Socially Appropriate Behaviour" and this was consistent across the State. Instruction in all other discrete skills was reported to be for between 47% and 56% of clients except for independent travel where 23% of Metropolitan clients received instruction in this activity compared with only 7% of Country clients.

■ Independent Living Skills Programmes

Table 6.7 provides a summary of information received relating to this programme area. As shown, 52 of the 58 (90%) ADTC's offered Shopping Programmes, with a greater proportion (96%) of Country Centres offering instruction in the activity. Cooking was also offered by most Centres (84%) and was once again more popular in Country ADTC's (89%). Instruction in Banking (83% of Centres), Money Value (83%), Traffic and Road Awareness (78%), Health and Hygiene (79%), Basic Self-Care (76%), Survival Reading (74%) and Budgeting were also readily available at most locations, with Traffic Awareness (81%), Health and Hygiene (84%) offered at more Metropolitan Centres than Country Centres.

More than half (54%) of all ADTC clients received instruction in accessing generic services and accessing the local community (50%). As shown in Figure 6.29 and 6.30, both of these programmes were provided for significantly more Metropolitan clients (generic services = 63%; local community 62%) than people in Country Centres (generic services = 40%; local community 32%). A similar pattern appears in relation to instruction in Shopping (Metropolitan = 52%, Country 44%), Cooking (Metropolitan = 51% compared with 37% Country) and Traffic Awareness (Metropolitan = 53%, Country 28%).

Table 6.7: INDEPENDENT LIVING SKILLS PROGRAMMES OFFERED TO ADTC CLIENTS IN VICTORIA

Discrete Skill Area	Country Regions Centres		Metropolitan Regions Centres		Statewide Centres	
	No.	%	No.	%	No.	%
1. Public Transport Familiarisation	10	37	21	68	31	53
2. Traffic/Road Awareness	20	74	25	81	45	78
3. Public Transport Usage	12	44	21	68	33	57
4. Travel Training (Home → Centre)	10	37	13	42	23	40
5. Home Maintenance	14	52	20	65	34	59
6. Shopping	26	96	26	84	52	90
7. Cooking	24	89	25	81	49	84
8. Basic Self Care (including toileting, dressing & showering)	21	78	23	74	[illegible]	76
9. Health & Hygiene	20	74	26	84	46	79
10. Survival Reading	22	81	23	74	45	78
11. Budgeting	23	85	20	65	43	74
12. Banking	23	85	25	81	48	83
13. Money Value	24	89	24	77	48	83
14. Coin Recognition	22	81	22	71	44	76
15. Basic Writing (name, address etc)	21	78	23	74	44	76
16. Form Filling	19	70	22	71	41	71
17. Accessing Generic Services	21	78	24	77	45	78
18. Access to Local Community	17	63	26	84	43	74
19. Consumer rights and responsibilities	17	63	22	71	39	67
TOTAL NUMBER IN SURVEY	27	100	31	100	58	100

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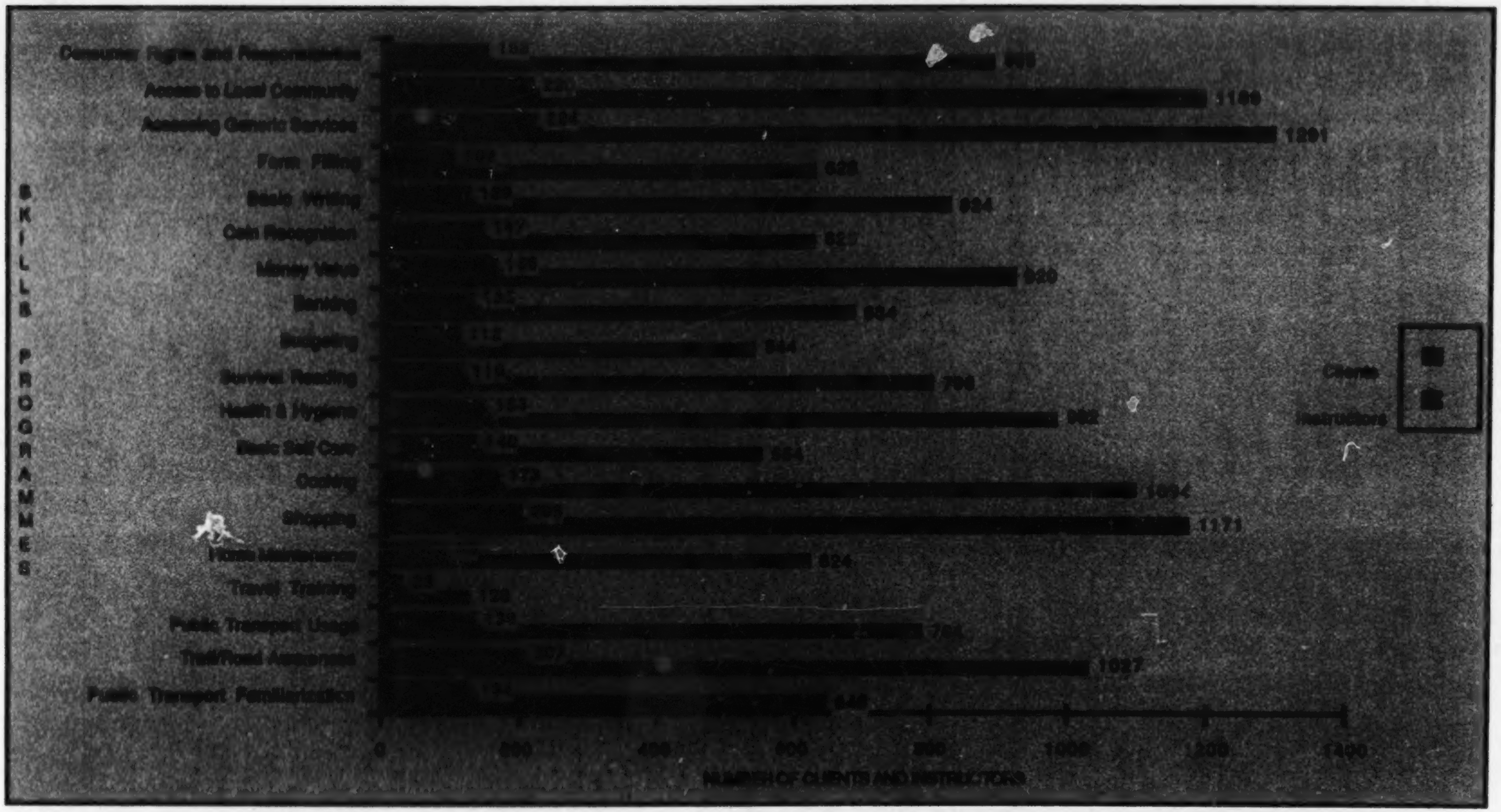

Figure 6.28: ADTC CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE INDEPENDENT LIVING PROGRAMMES IN VICTORIA

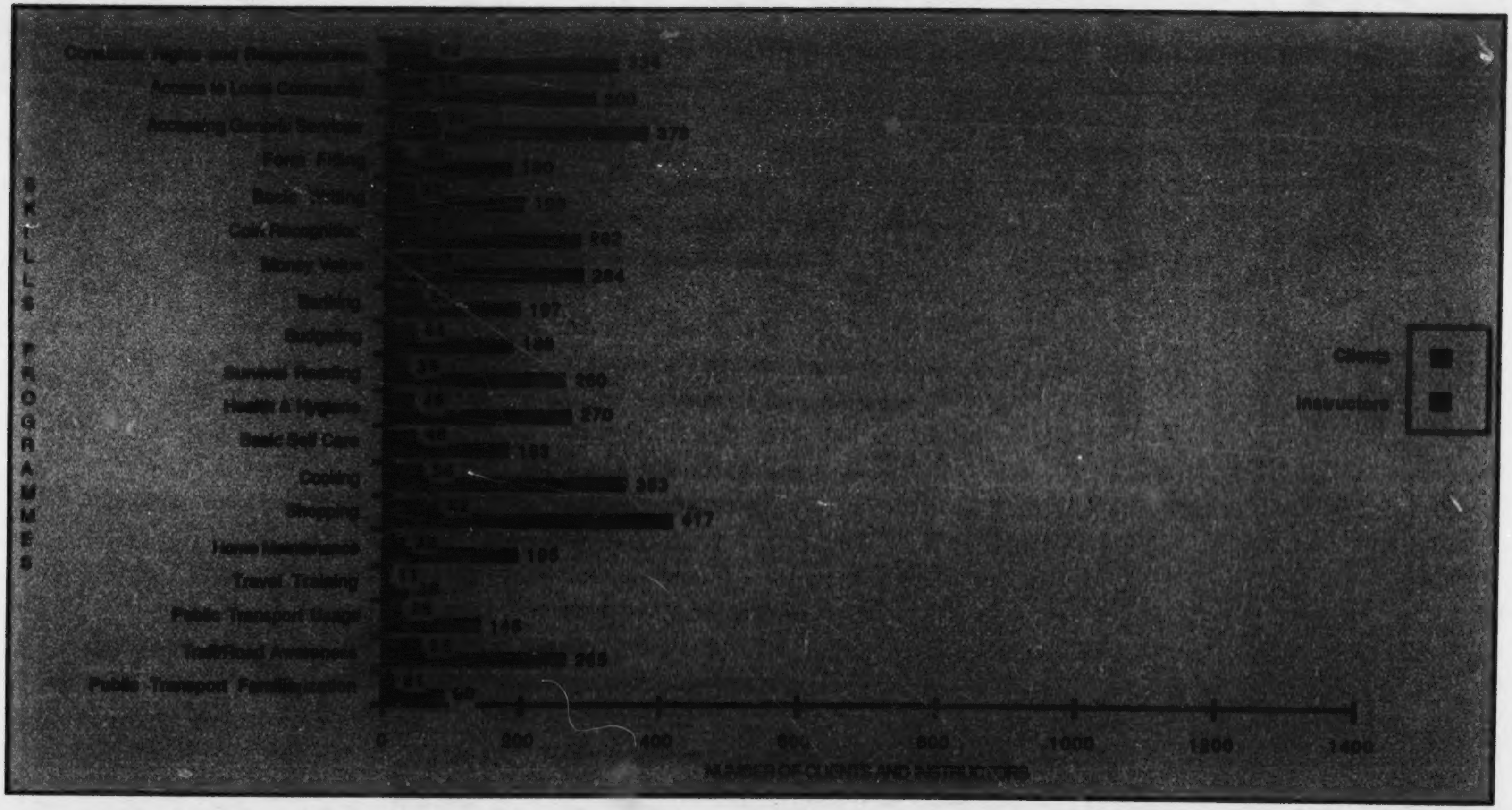

Figure 6.29: CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE INDEPENDENT LIVING PROGRAMMES OFFERED BY RURAL ADTC's

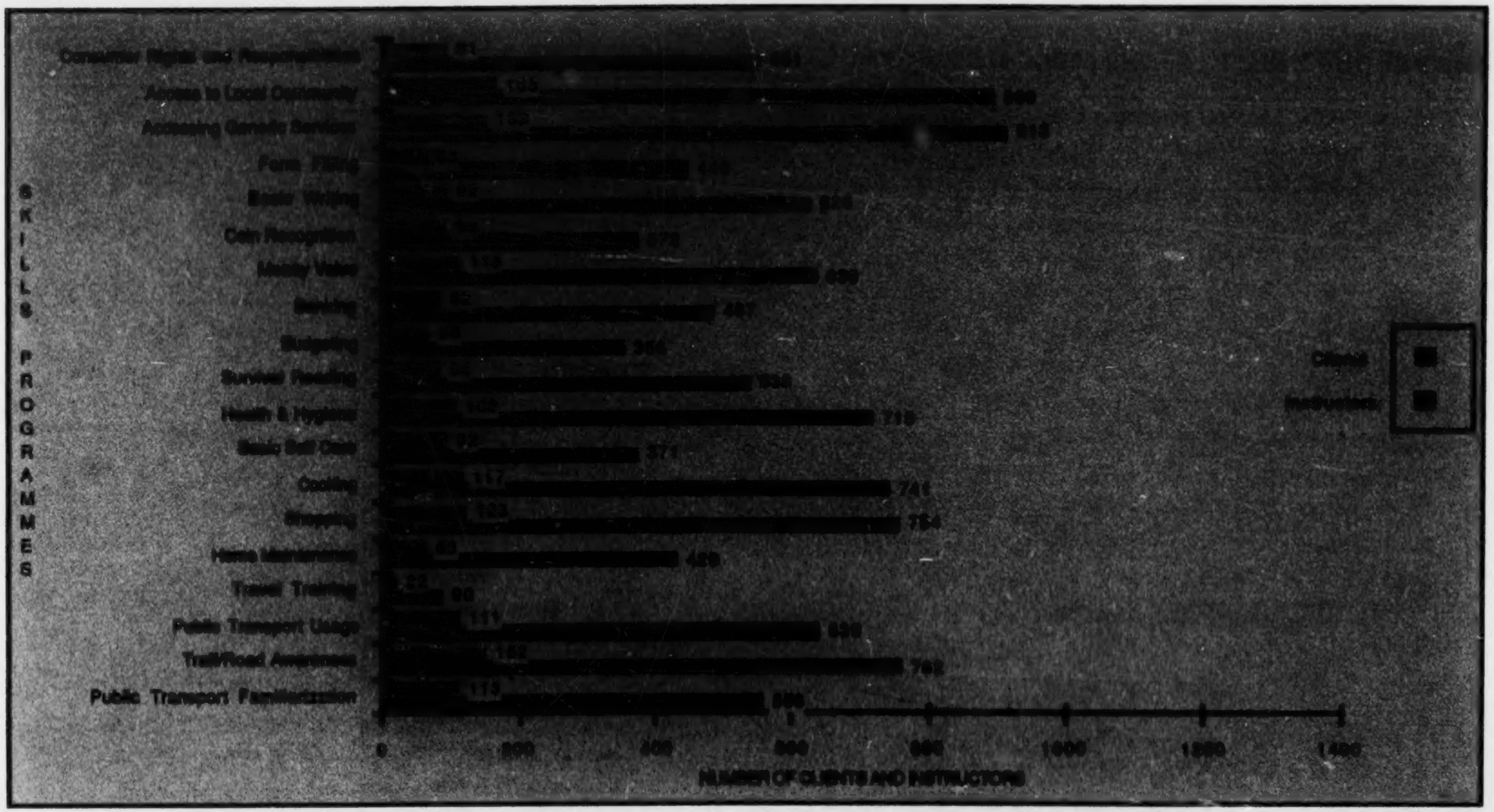

Figure 6.30: CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS DISCRETE INDEPENDENT LIVING PROGRAMMES OFFERED BY METROPOLITAN ADTC's

▪ Socialization

The summary of programmes offered in the Socialization/Human Relations area (see Table 6.8) indicates that 49 of the 58 ADTC's (84%) offer instruction aimed at "developing self image" and that this occurred in more Metropolitan Centres (90%) than Country Centres (78%). "Awareness of rights" was also offered by most centres (81%) as was instruction in "appropriate social interaction" (81%), with the later being offered by more Metropolitan Centres (87%) than Country Centres (74%).

As displayed in Figures 6.31, 6.32 and 6.33, the largest number of Centres offered instruction in "appropriate social interaction" (68%), "age appropriate behaviour" (67%) and both were more popular in Metropolitan Centres (73 and 72% respectively). The least number of Centres offered instruction in sexual awareness (30%).

Table 6.8: SOCIALIZATION/HUMAN RELATIONS PROGRAMMES

Discrete Skill Area	Country Regions Centres		Metropolitan Regions Centres		Statewide Centres	
	No.	%	No.	%	No.	%
1. Development of Self-Image awareness	21	78	28	90	49	84
2. Awareness of Chain of Authority within a System	16	60	18	58	34	59
3. Awareness of Rights (Self/Others)	21	78	26	84	47	81
4. Age Appropriate Behaviour	19	70	27	87	46	79
5. Alternative Coping Strategies	17	63	25	81	42	72
6. Appropriate Social Interaction	20	74	27	87	47	81
7. Independence & Responsibility	22	81	24	77	46	79
8. Awareness of Action—Consequences relationship	20	74	24	77	44	76
9. Awareness/Understanding of Sexuality	18	67	25	81	43	74
TOTAL NUMBER IN SURVEY	27	100	31	100	58	100

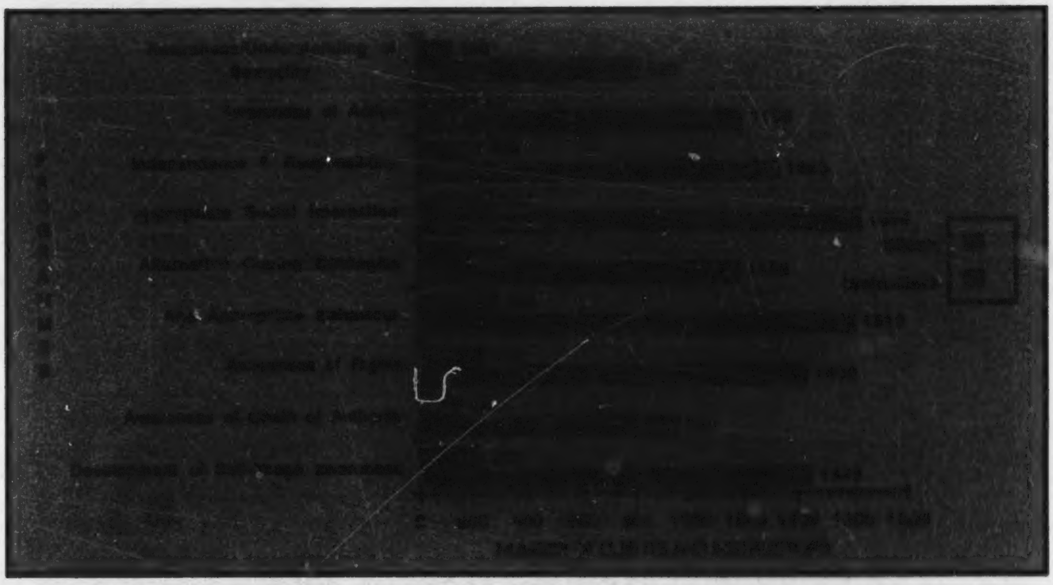

Figure 6.31: ADTC CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS SOCIALIZATION PROGRAMMES IN VICTORIA

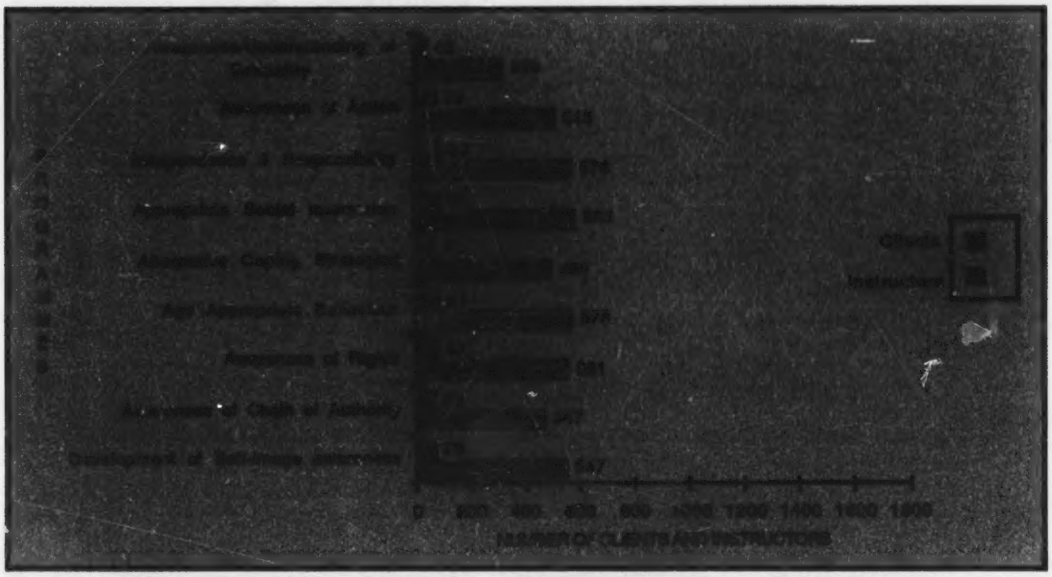

Figure 6.32: CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS SOCIALIZATION PROGRAMMES IN RURAL ADTC's

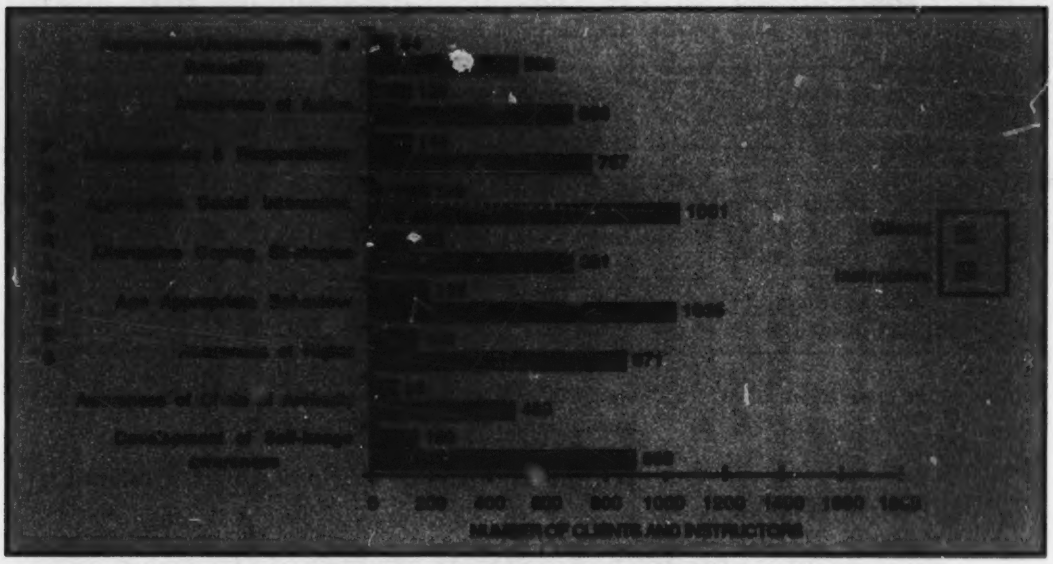

Figure 6.33: CLIENTS AND INSTRUCTORS ENGAGED IN THE VARIOUS SOCIALIZATION PROGRAMMES IN METROPOLITAN ADTC's

▪ Behaviour Management Programmes

44 of the 58 Centres, (76%) reported that they conducted behaviour management programmes, 19 Country Centres and 25 Metropolitan Centres. As shown in Table 6.9, 38 Centres (66%) used such programmes to decrease client behaviour regarded as socially unacceptable and 20, or 34% of all ADTC's participating in this survey, used behavioural programmes to increase low-level desirable behaviours.

Table 6.9: TYPE OF BEHAVIOUR CHANGE PROGRAMMES CONDUCTED IN ADULT DAY TRAINING CENTRES

Programmes	Country Centres		Metropolitan Centres		Statewide	
	No.	%	No.	%	No.	%
To increase low-level desirable client behaviours	7	26	13	52	20	45
To decrease socially unacceptable client behaviours	14	52	24	96	38	86
No reported use of Behaviour Change Programmes	6	[illegible]	6	24	14	32
TOTAL NUMBER IN SURVEY	27	100	25	100	44	100

Table 6.10: SETTINGS IN WHICH BEHAVIOUR MANAGEMENT PROGRAMMES OCCURRED

Programme	Country Centres		Metropolitan Centres		Statewide	
	No.	%	No.	%	No.	%
In Centre	19	100	25	100	44	100
In Community as well as Centre	11	58	14	56	25	57
At Home as well as Centre	12	63	13	52	25	57
TOTAL NUMBER RUNNING PROGRAMMES	19	100	25	100	44	100

As detailed in Table 6.10, of the Centres who ran programmes in the Centre, 25 reported that these were also extended to the Community and the person's home.

Table 6.11: LEVEL OF DOCUMENTATION OF BEHAVIOUR MANAGEMENT PROGRAMMES

Programme Components Documented	Country Centres		Metropolitan Centres		Statewide	
	No.	%	No.	%	No.	%
Baseline data	10	53	14	56	24	55
Structure	8	42	10	40	18	41
Monitoring data	11	58	13	52	24	55
NUMBER RUNNING PROGRAMMES	19	100	25	100	44	100

Centres reported that formal data was not collected for all programmes, however baseline and monitoring data was collected in 55% of cases (see Table 6.11)

▪ Recreation and Leisure Programmes

All but eight ADTC's, four Country and four Metropolitan, reported that their Centres offered recreation programmes. These included gardening, bowling, swimming, gym, aerobics, films etc and typically occurred in Community settings. (See Table 6.12)

Table 6.12: RECREATION AND LEISURE PROGRAMMES

Programme	Country Centres		Metropolitan Centres		Statewide	
	No.	%	No.	%	No.	%
Recreation and Leisure	23	85	27	87	50	86
TOTAL NUMBER IN SURVEY	27	100	31	100	58	100

▪ Mature-Age Programmes

29 Centres, 14 in Country Regions and 15 in the Metropolitan area, which is 50% of ADTC's participating in this exercise, reported that they offered specific programmes for mature-aged clients. In 45% of cases, these programmes were aimed at retiring people from the Centre. In most cases (83%) programmes were operating in both Community and Centres and took priority over other Centre programmes for mature-aged clients in 25 of the 29 Centres.

- **Generic Adult Education Training Courses**

Table 6.13 indicates 65% of Centres in the Metropolitan area and 48% of Country Centres had clients enrolled in T.A.F.E. Courses. Community House Programmes were however more readily available for clients attending Country Centres (52% compared with 45%) as were C.A.E. Courses (33% compared with 13%). 17% of all ADTC clients attend these programmes (see Table 6.14).

Table 6.13: GENERIC ADULT EDUCATION OR VOCATIONAL TRAINING COURSES USED BY CLIENTS OF ADTC's

Agency	Country Centres		Metropolitan Centres		Statewide	
	No.	%	No.	%	No.	%
T.A.F.E.	13	48	20	65	33	57
C.A.E.	9	33	4	13	13	22
COMMUNITY HOUSE	14	52	14	45	28	48
TOTAL NUMBER IN SURVEY	27	100	31	100	58	100

Table 6.14: ADTC CLIENTS USING GENERIC EDUCATION/VOCATIONAL TRAINING COURSES

Training Courses	Country Regions		Metropolitan Regions		Statewide	
	No.	%	No.	%	No.	%
	154	16	250	17	404	17
TOTAL NUMBER IN SURVEY	950	100	1438	100	2388	100

6.3.5 Matching Clients to Programmes

As displayed in table 6.15 the most common methods of deciding which programmes for each client were through the GSP/IPP process and through an informal assessment of client need.

Table 6.15: MATCHING CLIENTS TO PROGRAMMES

Means of Enrolling Clients in Various Programmes	Country Areas	Metropolitan Areas	Statewide No.
1. Individual's need measured by formal assessment	237	498	735
2. Individual's need measured by informal assessment	408	647	1055
3. GSP/IPP process	312	749	1061
4. Level of disability	117	176	293
5. Client/Parent request	261	500	761
6. Client/Staff request	103	272	375

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6.3.6 Paramedical Services

Data summarized in Table 6.16 indicates that Speech Pathology was available to 48% of Centres and the services of a Psychologist at 40% of Centres. According to our data, physiotherapy was more readily available to Country Clients. In most Centres this type of service was available on a consultancy basis (Table 6.17).

Table 6.16: PARAMEDICAL SERVICES USED IN ADTC's

Service Area Programme Support	Country ADTC's		Metropolitan ADTC's		Statewide	
	No.	%	No.	%	No.	%
1. Speech Pathology	13	48	15	48	28	48
2. Physiotherapy	10	37	6	19	16	28
3. Occupational Therapy	9	33	3	10	12	21
4. Psychology	11	41	12	39	23	40
5. Other Paramedical	0	0	7	23	7	12
TOTAL IN SURVEY	27	100	31	100	58	100

Table 6.17: TYPE OF PARAMEDICAL SERVICE USED

Service Area Programme Support	Country ADTC's		Metropolitan ADTC's		Statewide	
	No.	%	No.	%	No.	%
Consultancy Role	19	70	16	52	35	60
Direct Programme Responsibility	1	4	2	6	3	5
TOTAL IN SURVEY	27	100	31	100	58	100

6.3.7 Support to Clients

Most ADTC's reported that they provided services which were not related to actual day programmes. Typically Centres commented that clients and their families frequently viewed the ADTC as "the service", and requested case-management, brokerage and advocacy assistance (Table 6.18).

Table 6.18: SUPPORT TO CLIENTS NOT DIRECTLY RELATED TO PROGRAMMES

	Country Regions		Metropolitan Regions		Statewide	
	No.	%	No.	%	No.	%
	25	93	28	90	53	91
TOTAL NUMBER IN SURVEY	27	100	31	100	58	100

Directors of Centres usually perform this role, but it was reported that instructors were also very involved in these activities (Table 6.19). Many respondents felt that such service provision was not properly their responsibility and many commented that they were not trained to deliver these services, but believed since no-one else provided this essential service they were obliged to do so.

Table 6.19: ADTC STAFF INVOLVEMENT IN NON-PROGRAMME SERVICE DELIVERY

Persons Providing Non-Programme Support	Country Regions		Metropolitan Regions		Statewide	
	No.	%	No.	%	No.	%
Committee of Management	2	7	4	13	6	10
Administrator	6	22	10	32	16	28
Director	24	89	27	87	51	88
Instructor	22	81	22	71	44	76
TOTAL NUMBER OF CENTRES IN SURVEY	27	100	31	100	58	100

6.3.8 Community Education Programmes

Our data indicates that 83% (N = 48) of Centres were actively involved in community education with all 48 Centres using the Local media. As shown in Table 6.20, the main target groups were Community Service Groups and Business and Employer Groups.

Table 6.20: TARGET GROUPS OF COMMUNITY EDUCATION PROGRAMMES RUN BY ADTC's

Target Group	Centres in Country Regions		Centres in Metropolitan Regions		Centres Statewide	
	No.	%	No.	%	No.	%
Business/Employer Groups	13	48	20	65	33	57
Community Service Groups	20	74	25	81	45	78
Lobby Groups	3	11	7	23	10	17
Other	6	22	12	39	18	31
TOTAL IN SURVEY	27	100	31	100	58	100

The main reported purpose of such activities was increased Community awareness, however Centres also used Community education techniques to assist in fund raising and client placement (Table 6.21)

Table 6.21: REPORTED PURPOSE OF ADTC COMMUNITY EDUCATION PROGRAMMES

Purpose	Country ADTC's		Metropolitan ADTC's		Statewide	
	No.	%	No.	%	No.	%
Fundraising	15	56	19	61	34	59
Increase Community Awareness	22	81	24	77	46	79
Client Placement	15	56	19	61	34	59
TOTAL NUMBER OF CENTRES IN SURVEY	27	100	31	100	58	100

6.3.9 Other Resources

- **Transport**

Centres reported that the types of transport shown in table 6.22 were available for daily us in accessing the local community.

Table 6.22: TRANSPORT TYPES USED BY CENTRES

Type	Country Centres		Metropolitan Centres		Statewide	
	No.	%	No.	%	No.	%
Centre Provided	24	89	24	77	48	83
Bus	9	33	17	55	26	45
Train	4	14	11	35	15	26
Tram	0	0	5	16	5	9
Taxi	13	48	17	55	30	52
TOTAL IN CENTRES SURVEY	27	100	31	100	58	100

Table 6.23 summarizes the total number of vehicles operated by Centres. Four Centres reported that they had no buses and four did not provide data.

Table 6.23: TOTAL NUMBER OF CENTRE-BASED BUSES

Type	Country Centres	Metropolitan Centres	Statewide
	No.	No.	No.
Cars	15	24	39
Buses	75	87	162
No buses	1	3	4
No Response	2	2	4

6.3.10 Funding Sources

- **Transport Funding**

The reported funding sources for vehicles is summarized in table 6.24. This indicates that most buses were funded by the State whereas cars were generally paid for out of Centre funds.

Table 6.24: TRANSPORT SUBSIDIES

Funding Body	Country Centres		Metropolitan Centres		Statewide	
	Bus	Car	Bus	Car	Bus	Car
Centre Funded	1	7	2	5	4	12
State Subsidy	19	4	18	0	37	4
Commonwealth Subsidy	0	—	0	1	0	1
Centre & State	5	—	4	—	9	—
Centre & Commonwealth	1	—	0	—	1	—
No Response	—	1	3	1	3	2

▪ Running Costs

The breakdown of reported funding sources is shown in Tables 6.25 and 6.26.

Table 6.25: FUNDING SOURCES FOR RURAL ADTC's

Funding Source	Percentage of Funds					Total Number Receiving Funds	No Response
	0–20%	21–40%	41–60%	61–80%	81–100%		
State Subsidy		1	6	11	5	23	4
Commonwealth Subsidy	22	1				23	4
Other Subsidy	15					15	4
Fees	12					12	4
Programme Generated	11	1				11	4
Fund Raising	18	1				18	4

Table 6.26: FUNDING SOURCES FOR METROPOLITAN ADTC's

Funding Source	Percentage of Funds					Total Number Receiving Funds	No Response
	0–20%	21–40%	41–60%	61–80%	81–100%		
State Subsidy	1		5	12	5	23	8
Commonwealth Subsidy	17	1			1	19	8
Other Subsidy	4					4	8
Fees	17					17	8
Programme Generated	10	3				13	8
Fund Raising	20	1				21	8

6.3.11 Committees of Management

Information received indicated that the role of Committees of Management was to take overall responsibility for the organizational policy, future direction and operation of their individual Centres. This included approving budgets, authorizing capital expenditure, ensuring service delivery, employing staff, promoting community awareness and in some cases raising funds.

6.3.12 Summary

Information received by the 10 Year Plan Team from 58 of the 68 ADTC's in Victoria indicates that nearly 2,500 adults with intellectual disabilities aged from late teens to retirement age received instruction in these Centres mainly on a full-time basis. Very few of these people are non-verbal or non-ambulant and most live at home with their families.

Programmes are delivered by almost 800 staff, of whom 60% are directly involved in direct client instruction.

Centres place their greatest emphasis on Vocational, Pre-Vocational and Independent Living Skills training and that this is more marked in Country Centres.

In the Vocational Programme area most clients are engaged in basic work skills sub-contract work training, and as yet, few are involved in actual employment, however work in paid enclaves are gaining in popularity and this is more marked in Country Centres.

Centres offer a wide array of training in activities of daily life, with more than half of all clients having instruction in accessing local community and generic services, however travel training to and from Centres is minimal.

In terms of "socialization" programmes, instruction in socially appropriate and age appropriate behaviours are provided for two thirds of clients.

Behaviour Management assistance is also offered in 70% of Centres, with slightly more than half of these carrying programmes over to the person's home and local community. Documentation of data and Programme structure is kept in about half of all cases.

Recreation programmes are offered in 86% of all Centres taking part in this survey and typically occurred in Community Centres.

Centres receive funds from a variety of sources, however, the State Government, through CSV/OIDS is the major funding source. Centres appear to run quite seperately from each other, with Committees of Management taking overall responsibility for all operations.

APPENDICES

CONFIDENTIAL

COMMUNITY SERVICES OF VICTORIA

OFFICE OF INTELLECTUAL DISABILITY SERVICES

Client Profile Checklist

Training Centre = ______________________ Date of Assessment = __________

Unit = ______________________

Assessor's Name: ______________________ Title: ______________________

____

Client's Name: ______________________ Date of Birth: ______________________

Sex: __________ Record No.: __________

Date of Admission: ______________________

Previous Institutionalization:

____

____

Family: Contact person: *Name:* ______________________ *Relationship:* __________

Address: ____

Telephone: ______________________

(Residential TCs) = Family involvement: Weekly; Monthly; Bi-annually;
Annually None.
Home visits; Outings; Telephone; Mail.

or

Living Situation: ____
(AD&Cs)

Secondary Disabilities

Please circle where appropriate

Sensory — Hearing : ____________________
(Name)
effect on mobility ____________________________________

— Visual : ____________________
(Name)
effect on mobility ____________________________________

— Other : ____________________
(Name)
effect on mobility ____________________________________

Motor — Cerebral Palsy: ____________________
(Name)
effect on mobility ____________________________________

— Other : ____________________
(Name)
effect on mobility ____________________________________

Medical — Epilepsy : Petit Mal
Grand Mal
Status
Frequency:

— Other : ____________________
(Name)
effect: ____________________________________

Behavioural: Severe stereotypic/Self Abusive Behaviours
Severe Behaviour Management Problem
Diagnosed Psychiatric Illness ____________________________________
(Name)

Is the person incontinent? Yes ____________ day
____________ night
NO

Community Living Skills Screening Check List

Instructions for use:

1. This form should be filled out by trained staff (CN or DCN or ADTC Director) who know the client well.
2. The question that this assessment asks is *DOES* the person perform each behaviour, *not* can s/he do it.
3. Score each statement thus:
   (A) If the person *actually* performs *all* of the behaviour independently.
   (B) If the person perform's the skills described in the statement with verbal, gestural and/or modelled cues from staff and/or some of the skills independently.
   (C) If the person cannot/will not perform the behaviour or does so with physical assistance.
   (D) If the person has no opportunity to exhibit the skill.
4. Please add extra comments if you feel they are relevant.

COMMUNITY LIVING SKILLS—CHECK LIST

Please circle appropriate response

1. *Personal Maintenance*

1.1 The person toilets, bathes, shaves and cleans teeth at appropriate times

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

1.2 The person demonstrates first aid in relation to cuts, burns, elevated temperature and choking.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

1.3 The person identifies and takes medication as required.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

2. *Dressing and Clothing Care*

2.1 The person dresses and undresses self (inc. zips, shoes).

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

2.2 The person collects, sorts, washes and stores own clothing.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

2.3 The person wears clothes that match, are clean, in good repair and appropriate in relation to setting and weather.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

3. *Eating and Food Management*

3.1 The person uses a knife, fork and spoon in a socially acceptable manner.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

3.2 The person prepares 3 cooked meals a day and shops from a grocery list.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

3.3 The person prepares balanced meals, prevents spoilage and maintains a supply of groceries.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

4. *Social Behaviour*

4.1 The person responds to verbal direction and demonstrates no stereotypic behaviours.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

4.2 The person understands and exhibits acceptable social behaviours and states consequences of unacceptable behaviours.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

4.3 The person demonstrates law-abiding behaviour and behaves sexually in a socially acceptable manner.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

5. *Expressive Skills*

5.1 The person indicates needs and responds to emotions.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

5.2 The person combines 2 or more words/signs/symbols in a meaningful way.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

5.3 The person uses the telephone and utilizes language in the community.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

6. *Home Living*

6.1 The person makes own bed, washes up, cleans floors and bathroom on a regular basis at approporate times.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

6.2 The person shows appropriate precautions with sharp objects, electricity, poisons, fire and emergencies.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

6.3 The person maintains each area in the householdand obtains necesary repairs on a regular basis.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

7. *Money Management*

7.1 The person identifies real money, makes a small purchase and performs a task to earn money.

A Independently
B With Verbal/Model
C Does not/Can not do
D No Opportunity

7.2	The person controls own money for one week, equates prices with money and compares needs and available money.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
7.3	The person uses a money system over time with reasonable accuracy.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity

8. *Time Awareness and Utilization*

8.1	The person gets up, goes to meals and activities at normal times.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
8.2	The person follows a daily schedule which allows for sufficient time to perform routine activities and gets to activities on time.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
8.3	The person follows a weekly routine and meets non-routine commitments on a regular basis.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity

9. *Recreation and Leasure Skills*

9.1	The person demonstrates spatial orientation and manipulative skills.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
9.2	The person participates in passive and interactive activities and maintains a hobby.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
9.3	The person attends leisure activites both as a spectator and a participant.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity

10. *Community Awareness and Utilization*

10.1	The person discriminates facilities in the home setting and their functions.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
10.2	The person gets to and from the community and demonstrates safety precautions with crossing intersections.	A Independently B With Verbal/Model C Does not/Can not do D No Opportunity
10.3	The person uses at least 10 community facilities on a regular basis.	A Independently B With Verbal/Model C Does not/Can not do D No Opport